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Full Name of Author — Nom complet de l'auteur

ASHA SINHA

Date of Birth — Date de naissance

~~Feb~~ July 21, 1940

Country of Birth — Lieu de naissance

INDIA

Permanent Address — Résidence fixe

14848-64 AVE. EDMONTON, ALBERTA

Title of Thesis — Titre de la thèse

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Name of Supervisor — Nom du directeur de thèse

DR. D. SAWATZKY

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COMMUNITY PREFERENCE FOR MENTAL HEALTH SERVICES FOR THE ELDERLY

by

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A THESIS

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NAME OF AUTHOR ASHA SINHA

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(Signed) Asha Sinha

PERMANENT ADDRESS:

14848 - 64 Avenue

Edmonton, Alberta

T6H 4Y4

DATED Aug. 6, 1981

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled "Community Preference for Mental Health Services for the Elderly" submitted by Asha Sinha in partial fulfilment of the requirements for the degree of Master of Arts in Community Development.

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TO THE MEMORY OF MY FATHER

ABSTRACT

The main purpose of the present study was to ascertain the nature of mental health services preferred by the community members in order to deal with the psychological problems of the aged. Specifically, the problem studied was whether people have a custodial orientation or community orientation for prevention, treatment and management of psychological problems in the elderly population. The relationship between attitude toward the elderly and preference for the services was also examined. In addition, the study investigated the relationship demographic variables have with preference for services for the psychologically impaired elderly, and with attitudes toward old persons. The following three instruments were used to obtain the required information: (1) Psychogeriatric Services Scales (PSS), (2) Old People Scale (OPS), and (3) Demographic Information Questionnaire (DIQ). The PSS was a specially constructed scale which measured preference for 27 different types of services representing 4 main categories: (a) Preventive Care, (b) Improved Institutional Care, (c) Community Care, and (d) After Care. The questionnaires were mailed to a random sample of 300 households in the city of Edmonton. Of these, 69 returns were complete enough for data analysis.

The results show that most respondents tend to prefer community oriented services for the psychological problems of the elderly. No one has definite custodial orientation. However, a significantly high percentage (63%) of the subjects have low community orientation,

whereas only 27% have high community orientation. With respect to the four groups of services, the highest preference is for Preventive Care Services followed by Improved Institutional Care, Community Care and After Care. As for the respondents' attitudes toward older persons, no subject has a definite negative attitude. However, a considerable percentage (41%) of the subjects have a low positive attitude toward the elderly as compared to those (23%) in the high attitude category. The correlation coefficient between attitude toward old persons and preference for services is small, suggesting that the nature of preference may not be predicted from the knowledge of one's attitude toward old persons. It is also found that, in general, most demographic variables are not related to either preference for services or to attitudes toward older persons.

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I. INTRODUCTION

Concern for the mental health of the elderly has increased considerably in recent years. Social scientists, mental health professionals and government officials have become aware of the high risk of mental disorders among the ages population. Lack of suitable mental health services for the elderly is also an important area of concern. It is generally agreed that mental health services require improvement and expansion in order to meet the needs of older persons. The gap between mental health needs and available services is too large to be ignored. Most gerontological researchers (Birren & Sloane, 1980; Glasscote et al., 1977; Zarit, 1980) suggest innovative government planning and a massive programme of social actions in order to develop and maintain adequate mental health services for the elderly.

World-wide demographic trends indicate a sharp increase in the older population (65 and over) since 1900. A significant further increase is expected in the year 2000 due to increased life expectancy. At present, about 8.5% of the Canadian population are 65 years of age or older (Statistics Canada, 1974). It is estimated that by the year 2001, persons who are 65 years and over will constitute nearly 11% of the total population of Canada. In the United States, the present older population is 10.5% and is expected to increase up to 16% by the year 2010 (United States Bureau of the Census, 1976). A similar trend of increasing population of older persons has been noted in European countries (Marquis Academic Media, 1977).

The demographic trend of the elderly population clearly indicates that the need for care services for both physical and mental problems of the elderly will increase dramatically in the near future. With respect to mental health, it may be noted that elderly people often suffer from extensive mental stress due to physical illness, low income, inappropriate living conditions, loneliness, bereavement and approaching death (Birren & Sloane, 1980; Butler & Lewis, 1977; Zarit, 1980). Therefore, they are more likely to develop psychological problems or mental disorders than any other age group.

Several studies (e.g., Butler & Lewis, 1977; Cohen, 1976) suggest that mental illness is more prevalent among older persons than in any other age group. It is estimated that 18-25% of the elderly suffer considerably from mental health symptoms (Roth, 1976). Many cases of depression, psychotic reaction and neurosis have been reported in the literature. Psychosis, the most serious form of mental disorder, increases significantly after the age of 65, and it is twice as common after age 75 as it is in the 25-35 year age group (Butler & Lewis, 1977). Senile dementia is considered as the fourth leading cause of death among the elderly (Katzman, 1976). The rate of suicide is also very high among persons over age 60 (Butler & Lewis, 1977). Alcohol and drug abuse problems among the elderly appear to be increasing. Even criminal behaviors have been observed in significant numbers.

Although medical needs of the elderly have been met to a considerable extent, their emotional and psychological needs have not

received adequate professional and governmental attention. It has been a common practice among professionals to neglect the emotional needs of older persons. The coverage of psychological services for the geriatric population under medical plans is extremely limited. Only a small percentage (1.3%) of the total mental health care fund is spent in North America for the care of the elderly (Cohen, 1976; Rombout, 1975). In fact, a large sum is spent on institutional care (nursing homes, mental hospitals, etc.). There are very few facilities in the community for the treatment and rehabilitation of the psychologically impaired elderly, although the epidemiology and history of mental disorders of later life have been fairly well understood.

In spite of the community mental health movement of the 1960's, and the introduction of the Community Mental Health Centre Act of 1963 which emphasized the access of mental health services as a civil right to all citizens, underrepresentation of the older population in community mental health facilities has remained unchanged. Most studies indicate that mental hospitals and psychiatric services in general hospitals are still primary facilities for the care of psychologically disturbed elderly. More than 75% of the elderly are living in nursing homes. Community mental health centers and out-patient clinics provide services to only a small proportion of the aged population. However, a number of studies have emphasized the importance of community based mental health services (e.g., Bergman et al., 1978). It has been noted that day hospitals, day care centers, half-way houses, sheltered workshops, mobile home services, walk-in clinics and social and recreational

facilities are better alternatives to institutionalization for the care of the elderly population, in general, and the elderly with psychological problems, in particular (Cohen, 1976; Goldstein, 1973).

Perhaps the main reason for the unavailability and underutilization of community based mental health services by the elderly population is the prevalence of negative and stereotypic attitudes of professionals as well as the general public toward old people. It is obvious that development, expansion and maintenance of adequate mental health programmes for the aged require strong community support.

The present research, therefore, examines the nature of community support for different kinds of mental health services for the elderly. The study also measures the relationship between attitude toward older persons and type of service orientation for the care of the mentally disordered elderly.

This study does not assume that all older persons have psychological problems requiring mental health services. The focus of this research is on mental health services for that segment of the elderly population which suffers from some form of psychological disability. Community preference for preventive mental health services has been determined in the present research for those in the 65 year and over age range who are at risk for mental illness.

Purpose of the Study

The main purpose of this research is to study community preference for mental health services for the elderly. An attempt was made to ascertain the type and nature of mental health facilities preferred by the community for prevention, treatment and rehabilitation of the psychologically disturbed elderly. Specifically, the purpose of this study was to determine whether the public prefers preventive, after care, community or custodial services. In addition, the study also measured community attitudes toward older people in order to examine the relationship between attitudes toward older persons and preference for mental health services. In summary, this study investigated the following topics:

1. What kind of mental health services are preferred by the community members to deal with the psychological problems of the aged? For example, do they prefer custodial care or community based services?

2. What attitudes are held by the community members about old persons?

3. Is there any relationship between attitude toward the elderly and preference for the type of mental health services?

4. Are there are relationships between attitudes toward old persons, preference for services and demographic variables such as age, sex, education, occupation, social class, and ethnic background of the community members?

Significance of the Study for Community Development

A major objective of community development is to achieve higher levels of economic, political and personal-social development for the underprivileged members of the society. It is generally recognized that older people, particularly in western societies, are underprivileged members of the community. They are treated as second class citizens in everyday living. Older persons with psychological problems are further neglected with respect to their needs for social and psychological services. The fast increasing older population has become a matter of social and political concern for the community. The quality of community life in any society is primarily related to the psychological well-being of the members. Hence, there is an urgent need for expansion of suitable psychological services for the elderly along with medical and social services. Research on these aspects of aging has important significance for the community.

In order to develop new programmes and obtain adequate financial support from the government, it is important to assess the extent of community support for such programmes. In this research project, an attempt has been made to determine the preference of the public for specific mental health services for the elderly. Findings of this study can be utilized by community development workers in establishing realistic guidelines for the expansion of existing services, development of new programmes and change of public attitudes in desirable directions.

A number of studies on attitudes toward the elderly have been

conducted in the United States and other European countries. A few studies have also been reported in Canada. However, the findings of these studies are not completely relevant for the community in Edmonton. Most studies have been carried out in well-established metropolitan communities. But Edmonton is a young and fast growing city with people of various cultural backgrounds. Attitudes of the community members in Edmonton, therefore, may differ significantly from the attitudes of people in more well-established communities.

The present research, therefore, is highly significant for community development dealing with old people who exist as an underprivileged group in the community. The findings of this study will be helpful to community development workers in planning and implementing appropriate programmes for rehabilitation and treatment of the elderly with psychological problems. Community development workers can also utilize their expertise in changing public attitudes toward older members of the community for the purpose of prevention of psychological problems in the rapidly growing population of the elderly.

II. REVIEW OF THE LITERATURE

1. Epidemiology and Nature of Psychological Problems in the Elderly

It is difficult to obtain precise data on the incidence and prevalence of various psychological problems of later life, primarily because of the lack of standardized and reliable case finding techniques and assessment methods (Redick, Kramer & Taube, 1973). Other problems encountered in the psychological assessment are lower expectations and lack of motivation shown by the elderly (Kramer & Jarvick, 1979; Schaie, 1978). In spite of the methodological limitations, research indicates that mental problems are extensive among the aged.

Butler and Lewis (1977) report that at least 3 million or 15% of the elderly in America have some form of mental disorder and require mental health services. Approximately 26% of the older population in San Fransisco were found to have moderate to severe psychopathology (Lowenthal et al., 1967). In 1970 about 125,000 persons aged 65 years and over were institutionalized in state and county psychiatric hospitals of America (Kramer et al., 1973). This study also found a small number of the aged in Veterans' hospitals (5,888) and in private hospitals (1,800). Other studies have estimated that a large number (70% to 80%) of the elderly living in nursing homes suffer from mental disorder (Busse & Pfeiffer, 1973; Butler & Lewis, 1977).

Kramer, Taube and Redick (1973) examined several studies of prevalence rates of mental illness among the non-institutionalized

elderly population. They noted that about 10% to 20% of the people aged 65 years and over were in need of mental health services. Similarly, Simon (1974) estimated that about 15% to 25% of the aged living in the community suffered from moderate to severe mental impairment.

With respect to the nature of psychopathology in old age, Butler's (1975) review of the literature suggests that the rates of psychoses, functional disorders (especially depression and paranoid states) as well as organic brain disorders increase steadily after the age of 60. A large number of studies have indicated that the most prevalent and serious mental disorder in old age is depression (Busse & Pfeiffer, 1978; Butler & Lewis, 1977; Epstein, 1976). According to Dovenmuehle, Pee, Reckless and Newman (1978), approximately 33% of 60-year-olds and over suffer from some form of depression. Garland (1976) estimated that 2% to 10% of the relatively healthy elderly living in the community were depressed enough to require clinical attention. As for the specific type of depression, several studies have shown that psychotic depression is more prevalent in age 60 or over (Garland, 1976; Hendricks, 1977).

Among other serious mental disorders of old age, clear evidence exists in the literature for the prevalence of paranoid states, hypochondriasis and organic brain syndrome. However, the incidence and prevalence of schizophrenia in old persons are still debatable (Bergman, 1975; Carpenter, 1976). Fish (1960), and Roth and his associates (1972) found that 10 to 16 per cent of the elderly admitted to psychiatric wards had paranoid symptoms. More than 50% of the patients in the old age group manifest hypochondriachal symptoms, and a majority of them are

women. However, it may be noted that the diagnosis of hypochondriasis is often confounded by real health problems of old age (Busse & Pfeiffer, 1973; Butler, 1975). Organic brain syndrome is found in 10% of the elderly population (Jolley & Arie, 1978). Among the mentally impaired elderly, approximately 50 per cent have organic brain disorder (Kramer, Taube, & Redick, 1973). But some clinical studies suggest that 10 to 20 per cent of cases of organic brain syndrome are reversible, because they are due to error in medication, malnutrition, metabolic imbalance or other unspecified causes (Butler & Lewis, 1977; Libow, 1977).

Perhaps the most tragic problem of the elderly is suicide. The incidence of successful suicide among the aged is considerably higher than in any other age group (Busse & Pfeiffer, 1973; Pfeiffer, 1977). In 1970, the suicide rate in the U.S.A. for the total population was 11.6 per 100,000. But it was 36.9 per 100,000 for persons in the old age category (Vital Statistics, 1974). Thus the suicide rate among the elderly is more than 3 times the rate for other age groups. A similar trend has been observed in European countries (Sainsbury, 1962). Factors such as depression, social isolation, chronic physical illness, deteriorating economic conditions, have been considered to have contributed to the high incidence of suicide among older persons (Barraclough et al., 1974; Bock & Webber, 1972; Garland, 1976).

Serious problems with alcoholism and drug abuse have been observed in many old persons. In a recent survey of agencies treating alcoholics, 18% of the clientele were found to be 55 years or older

(Wood, 1978). Two Scandanavian surveys show that 16% of the alcoholics belong to the 60-69 age group (Essen-Moller, 1956; Hagnell, 1972). A significant number of alcoholics are also in community mental health centers, psychiatric out-patient clinics and mental hospitals (Gaitz & Baer, 1971; Redick et al., 1973). Gram (1961) reported at least 20% of nursing home residents suffering from alcoholism. Several studies suggest that about 5 to 10 per cent of psychologically disturbed elderly have problems with alcohol (Busse & Pfeiffer, 1973; Daniel, 1972; Gaitz & Baer, 1971).

A related matter of concern in the medical profession is over use and misuse of drugs by older persons (Morrant, 1975; Zimberg, 1974). Bataden (1974) found that 25% of all prescribed drugs were used by the elderly, even though they constitute only 10% of the American population.

It is evident from this selective review of research that psychological problems of the elderly are numerous and varied in nature. Effective treatment and management of these problems will necessitate improved facilities, specialized services and trained professionals.

2. Nature of Mental Health Services

In spite of noticeable increase in psychological problems among the elderly population, there is a conspicuous lack of mental health services specially designed for older persons. This situation exists in both institutions and in community centers. Active treatment programmes for the aged are found only in a few mental hospitals. Mental

health services are rare in nursing homes and extended care centers. Thus, the majority of institutionalized elderly with mental disorder or psychological problems do not receive any professional mental health service. Instead, they are given mainly custodial and social care (Busse & Pfeiffer, 1973; Butler, 1977). Dr. Butler (1973) predicts that if the present level of service continues in the 1980's, then 80% of the elderly will not receive any kind of psychological care. It is clear that there is an urgent need for mental health services for the growing elderly population.

In recent years, concern for the welfare of elderly citizens in Canada and the United States has given impetus to the development of various mental health programmes. These new services and facilities include psychogeriatric units in mental hospitals and general hospitals, extended care centres, geriatric day hospitals with short-term and long-term care orientation, geriatric day care centres, walk-in clinics, meal-on-wheels, outreach services, home care services, and comprehensive psychiatric service centres (Busse & Pfeiffer, 1973; Butler & Lewis, 1977; Goldstein, 1973; Kramer et al., 1973). Studies have shown that all these services are effective to a certain extent in prevention, treatment and rehabilitation of the elderly with psychological problems (Flathman & Larson, 1976; Goldstein, 1968; Lipscomb, 1971; Lawton & Gottman, 1974). Although there are few comparative studies to evaluate the relative effectiveness of various psychogeriatric programmes, research suggests promising outcomes with day hospitals, home care services, out-patient services and comprehensive psychiatric services.

These services are discussed here briefly.

Day Hospitals

The beneficial effects of day hospitals with long- and short-term care orientation have been confirmed in several studies. In England, Baker and Byrne (1977) observed day hospitals as the preferred area of treatment, even for the severely disturbed elderly. The rate of admission to state mental hospitals has been reduced by more than 50% by the provision of short-term treatment facilities in day hospitals (Baker, 1968; Brody, 1967). In Alberta, three pilot day hospitals were studied by Flathman & Larson (1976) who found them more useful and less costly compared to any long-term institutional care.

Although the day hospital is considered a better alternative to permanent hospitalization, it has several limitations. The utilization of services provided by day hospitals depends upon an adequate and well-organized transportation system. Moreover, the elderly must have high motivation and desire to receive the services. Many old people are confused and as such are unable to utilize day hospitals. Another issue with day hospitals is the range of services available to the elderly. Goldstein and his associates (1968) noted the lack of facilities in day hospitals for the treatment of confused and paranoid older persons. However, they concluded that a comprehensive programme in day hospitals will be more effective in meeting the rehabilitation needs of a large number of the elderly.

Emergence of geriatric day hospitals is a recent phenomenon in the United States. In Canada, day hospitals for the elderly have been

established in only a few large cities, such as Montreal and Winnipeg. In contrast, geriatric day hospitals were started in Great Britain in the 1950's, and there are more than 150 such hospitals at the present time (Brocklehurst, 1973).

Psychiatric Home Care Services

A major goal of geriatric services has been the prevention of permanent institutionalization of the elderly population. There are two main programmes in psychiatric home care service: (1) emergency care for those who are suicidal, and (2) on-going therapy for those who have difficulty in coping with the problems of old age (Butler & Lewis, 1977).

In England and other European countries, home care services have assumed increasing importance in the community service system for the aged (Rathbone & McCuan, 1976; Raskin, 1973). There are very few such programmes in Canada and the United States, although a conservative estimate by Brody (1973) suggests that one out of three mentally disturbed elderly need psychological services at home.

Out-Patient Services

Mental health services for the elderly living in the community are extremely inadequate. Only 3% of the mentally impaired elderly attend out-patient clinics attached to hospitals, and 2% are in psychiatric clinics of community mental health centres (U.S. DHEW, 1976). Similarly, Butler points out that only 2% of a psychiatrist's time in private practice is given to the elderly.

Comprehensive Mental Health Service

Perhaps the best facility to provide out-patient care as well as other required psychological services is a comprehensive community mental health centre. A comprehensive programme which offers medical, social, psychological, financial, recreational and rehabilitation services has been found most effective in dealing with the whole range of mental disorders in the elderly without institutionalization (Goga, 1977; Kobrynski, 1968; Simon, 1968).

Underrepresentation of the elderly population among the clients of community mental health centers may be due to "discrimination" against the aged, as suggested by Patterson (1976). But in fact, most community mental health centres do not have preventive and after-care services for the elderly (Stotsky, 1973).

Inappropriateness of Services

A valid criticism of the existing mental health services is that they are not oriented toward the needs of the older population. Traditional approaches to treatment and management must be changed in order to accommodate the unique personal and social needs of the elderly (Lebray, 1979). Skeleton's (1977) study in England also found that needs of the elderly are overlooked by health and welfare services.

It appears that mental health professionals believe in the idea of "providing services" rather then "designing services" according to the needs of the population (Gatz et al., 1980).

Lack of Trained Professionals

The lack of psychological services for the aged may also be due

to the scarcity of trained professionals. At the present time, there are very few geriatric clinicians in the United States, and they are non-existent in Canada. The demand for professionals in this field is expected to be enormous in the near future. Kramer et al., (1973) estimate that more than 90,000 professional psychologists are needed to serve the geriatric population, whereas only 44,800 are probably working in the field at the present time. Others have estimated the need for professionals more conservatively. Lindsey (1977) and Birren and Sloane (1977) believe that more than 2,000 geriatric clinicians will be needed within the next 10 years. This overdemand and undersupply situation will also apply to psychiatrists, social workers, and nursing staff.

High Cost

Underutilization of mental health services by the elderly has been explained in terms of high cost (Gatz, 1974). Medicare systems in both Canada and the United States provide only limited coverage of psychological services. However, some researchers believe that increased funding of psychogeriatric programmes will not necessarily improve the situation. Instead, the elderly should be actively involved in the design, planning, modification and evaluation of the existing mental health services.

Utilization Pattern of Mental Health Services

Institutional Care

The community mental health movement of the 1960's in America

put great emphasis on deinstitutionalization of psychologically disturbed persons. However, most studies indicate that mental hospitals and psychiatric wards of general hospitals are still primary facilities for the care of psychologically impaired elderly (Busse & Pfeiffer, 1973; Butler, 1977, Lowenthal et al., 1967; Kramer, 1969). In 1970, about 1 million old persons in the United States were in some kind of mental institution, such as state, county, veterans' and private hospitals (Butler, 1977; Fredrickson, 1977; Frankfather, 1977, Kaplan, 1979; Kramer, 1969). The patients who are 65 years or over constitute 20% of the population of mental hospitals in the United States (DH SS, 1975).

Institutionalization of older people in Canada is significantly higher than that in most industrialized countries of the world. About 9% of Canadians over the age of 65 years are in institutions in contrast to about 5% to 6% in Great Britain and the United States (Tesher, 1976). Within Canada, Alberta has the highest percentage of senior citizens in various institutions (Peto, 1980). Englemann and Harper (1978) report that 12% of 65-year-olds and 25% of 75-year-olds are institutionalized in Alberta. Within the city of Calgary, a similar study found that the public thinks of institutional placement spontaneously when a person reaches old age, regardless of his/her mental and physical conditions (Peever, 1974).

The deinstitutionalization movement in America since 1960 may be credited for some reduction in the admission of older persons in state hospitals. However, the admission rate of the elderly with psychological problems has increased in nursing homes. Pfeiffer (1977)

believes that almost 80% of the aged living in nursing homes have some form of mental problem. Berezin's (1970) study indicates the presence of chronic brain syndrome and other serious psychopathology in 87% to 90% of the elderly residents in nursing homes. Several European studies also report high prevalence rates of mental disorders in elderly nursing home residents (Ciompi, 1966).

In spite of the fact that a large number of nursing home residents suffer from serious mental problems, they receive little or no professional mental health service. Winn and Kessler (1974) reported that 95% of nursing homes did not have any psychologist on staff, and only 25% had social workers. The authors further noted that the nursing home staff were inadequately trained to deal with the psychological problems of the elderly residents. They were mostly given tranquilizers to control their behavior (Glosscote et al., 1976).

Another controversial issue among professionals is the practice of transferring older mental patients from mental hospitals to nursing homes, particularly when there is no provision for mental health service in nursing homes (Feldman, 1974; Khazzji et al., 1974). Many researchers consider nursing homes as mini hospitals with the same disabling effects as is the case with mental hospitals. The nursing home industry has become a good profitable business for many rich people (Butler & Lewis, 1973). Insofar as the aged mental patients are concerned, the community mental health movement has, in fact, produced a paradoxical increase in custodial care in nursing homes.

Mental Health Services in the Community

Precise information about the utilization pattern of community

based mental health services by the elderly population is unavailable in both Canada and the United States. However, studies in this area clearly suggest that a very small percentage of the elderly make use of available resources in the community. Kramer, Taube and Redick (1973) reviewed the admission rate of people over 65 years in psychiatric facilities and concluded that a very small number actually received community psychiatric care. Only 2% of the clients in the 65-year and over age category used out-patient clinics. The researchers further noted that only 4% of the elderly utilized the services of community mental health centers. Thus, the number of persons seeking out-patient care declines with increasing age. A similar pattern has been reported by Kahn (1975) who found only 3% of the elderly utilizing out-patient services.

Overview

The fact that the elderly suffer from a variety of psychological problems has been well-documented in the geriatric literature. However, the present mental health system is mainly oriented toward the treatment of acute episodes of mental illness through hospitalization in mental hospitals or in psychiatric wards of general hospitals. In the case of chronic mental problems, the most common practice appears to be placement of the elderly in nursing homes. Even those who are initially admitted to mental hospitals are frequently transferred to nursing homes. Unfortunately, professional care is non-existent in nursing homes because usually they do not have mental health professionals on staff.

The institutionalization pattern clearly indicates that a

custodial care philosophy for the aged is still prevalent. In fact, mental health problems of the elderly have been ignored so much that for many older persons institutionalization is the only practical alternative. This fact suggests that provision for early utilization of mental health services must be made within the community. In addition the professional interest should be more on preventive and after-care services than on treatment or custodial care.

It should be noted that in recent years both the government and the public have become interested in the problems of the elderly. Because of increased government funding, professional interest and public support, improved facilities for mental health problems of the elderly are being developed in both Canada and the United States. These geriatric facilities are community oriented and attempt to help the elderly live independently and with dignity. However, continual funding for geriatric research is necessary in order to understand the interactions between personality factors, physical conditions, economic trends and sociocultural factors. Finally, all new and traditional mental health programmes for the elderly must be evaluated regularly so that comprehensive mental health service programmes can eventually be established.

A comprehensive approach to the treatment of older persons, according to Zarit (1980), should include (1) accommodation services (i.e., housing) for the physical maintenance of the elderly, (2) clinical services (eg. therapeutic programmes), and (3) life enhancing and preventive services. Since older persons are prone to a combination of medical and psychological problems, the comprehensive approach for the

prevention, treatment and rehabilitation is likely to be effective.

3. Attitudes Toward Old Age and Old Persons

Historical and Cultural Perspective

Historically, public attitudes toward old age and older persons in the Western culture have been generally ambivalent. Simone de Beauvoir (1972) presents an interesting comparison between the viewpoints of Plato and Socrates on one hand, and Aristotle on the other. Both Plato and Socrates had positive attitudes, whereas Aristotle had extremely pessimistic notions about old people. Plato believed that body and soul were not subject to the same forces of decline. Physical aging of the body produces freedom of mind in order to engage in more positive and higher level of thinking and work. Plato also believed that only people over age 50 were capable enough to run the affairs of the state. According to Socrates, young people could only learn through the company of older persons. In contrast, Aristotle believed that men advanced only up to the age of 50 after which there was deterioration in both mental and physical abilities. He further stated that the elderly lived more in the past and possessed little hope for the future. Such a negative view on aging seems to be prevalent in present-day thinking as well. Older persons are generally undervalued because they are believed to have diminished capacity to produce.

Ansello (1977) has examined values and attitudes toward the elderly during the course of Western civilization. He finds that values

by which old people are evaluated and attitudes most closely related to those values have not changed significantly from the ancient Greek society to the modern society. What has changed noticeably is the number of old people with healthy and productive lives. Therefore, more and more old persons are likely to be affected by negative public attitudes.

Attitudes toward old people vary from culture to culture. Cultural norms and values determine the ways in which old age and the elderly are perceived by the general population. These factors also influence the self-concept of old people as well as their own perceptions of old age. In general, traditional, primitive and agricultural societies where the extended form of family is prevalent, old age and older people are respected and valued for their accumulated knowledge and wisdom. They exert a great deal of power and influence in the family as well as in the community.

By way of contrast, in the Western culture rapid social and technological changes have drastically reduced the influence and status of older persons. Since the production of material goods and services is the central feature of the contemporary Western societies, old age has become a liability. A person's worth is measured in terms of his present competitive work performance rather than experience or past contributions. Such values and norms have taken away the traditional role and status from the elderly. Old people have lost virtually all prestige and power in the community. They are generally considered as useless members of the society because of a decline in their ability

to make a meaningful contribution to the society. In fact, older persons are seldom treated as persons with individual identities, personal needs, feelings and emotions. This impersonal public atittude is closely reflected in the lack of appropriate care facilities available for the elderly in the community. Atcheley (1972) presents a realistic picture of old age and older people in Western society:

> From a purely practical point of view old age itself is a stigma . . . . By far the most important aspect . . . is its negative, disqualifying character. On the basis of their age, older people are usually relegated to a position in society in which they are no longer judged to be of any use or importance. Like most other expendable elements in society, older people are subjected to poverty, illness and social isolation (p. 14).

It is well-documented in the research literature that most community members, professionals and para professionals hold negative and stereotypic attitudes toward old age and older people. Dr. Butler (1975), an overt critic of the status of older people in society, has used a general term, "ageism", to describe existing prejudices and sterotypes on the basis of age alone. He explains that ageism like racism and sexism is a whole-sale discrimination against all members of a category who are separate from other members of the population on the basis of certain physiological characteristics. Like racism and sexism, ageism also hinders individual growth and uniqueness. Moreover, ageism appears in more covert forms. Lack of sufficient social security allowance, inadequate health care facilities, and the belief that those over sixty do not benefit from psychotherapy are some examples of subtle, or in some cases not subtle, consequences of old age. Ageism is present in the myth which perpetuates the belief that the elderly are somehow

different from our present and future selves, and as such they do not have the same desires, concerns and fears. Ageism can also be attributed to the emphasis given by the Western culture on productivity and technological expertise. Prejudice and negative attitudes toward older people may also be an attempt by the younger generation to shield themselves from the inevitable fact of their own aging. Ageism also provides avenues to avoid dealing with social and economic problems arising from the increasing population of older persons. This also provides justification for the removal of the elderly from the job market at a specified age without adequate compensation. As Dr. Butler (1977) explains, "Ageism is the sacrifice of older people for the sake of 'productivity' and the youth image that the working world feels compelled to project (p. 141)".

Public Attitudes

Public attitudes toward old people have been found to be highly negative in a number of studies (Harris et al., 1975; McTavis, 1971; Riley & Foner 1968; Signori et al., 1977). Also, it has been observed that the public has specific myths and beliefs about old people which most likely give rise to negative attitudes (Butler, 1975, Harris et al., 1975; Hess, 1974; Payne & Whittington, 1976). In order to understand the source of negative attitudes in the general population, researchers have focused upon stereotyping of the elderly rather than specific attitudes. Old people are usually judged and evaluated on the basis of distinctive stereotypic beliefs (Bringmann et al., 1968; Eisdorfer, 1966; McTavish, 1971; Seltzer & Atchley, 1975). For example, older

people are perceived as "foreign class of object" specially by young people, which leads to more generalized stereotypes (Bengston, 1971; McTavish, 1971; Riley & Foner, 1968).

Attempts have been made to identify these myths and stereotypes about older persons among the general public. Butler (1975) observes five general myths underlying stereotypic beliefs about old age. These are: (1) myth of resistance to change, (2) myth of unproductiveness, (3) myth of tranquility, (4) myth of senility, and (5) myth of chronological aging. These myths and associated stereotypes have been noted by other researchers as well.

The public feels that older people resist any kind of change in society. They are not able to adapt to social changes that are always occurring in a dynamic society (Harris, 1975; McTavish, 1977). Even the elderly themselves believe that they are unadaptable to change (Harris, 1975; Riley & Foner, 1968, Kirkpatrick, 1976). Harris et al. (1975) and McTavish (1971) also noted the general belief that older persons are uninvolved and do not contribute anything to society. In the studies of Harris (1975), and Riley and Foner (1986), old age was viewed as a period of serenity, tranquility and peacefulness by most people. This was considered a time to relax and enjoy life rather than being involved in social and family affairs. This view projects complete isolation of older persons from the mainstream of the society.

The myth of "senility" appears to be common among the general public. The older person is characterized as forgetful and confused with a short attention-span. However, Butler (1975) points out that

there is no definite medical condition called "senility". What has happened is that natural human responses to the problems of the elderly, such as grief, depression and anxiety are lumped together under the concept of senility. These natural responses are then explained as due to the process of aging (Eisdorfer & Altrocchi, 1961).

Perhaps the most damaging stereotype is related to the myth of chronological aging. As a person grows older, he begins to show a decline in mental and physical abilities. Thus, at a certain age, all persons are expected to show signs of old age in their thinking and behavior. The typical retirement age of 60-65 years is a manifestation of the public belief that those who are 60 and over are not capable of being as productive as people who are younger in age. According to Harris (1975), about half of the population of the United States believed that the onset of old age was related to chronological age. This stereotype is, in fact, based upon an unsubstantiated belief in the biological aging process (Ansello, 1977).

Researchers have also identified a variety of stereotypes about the aged. Riley and Foner (1968) report that both young and old believe elderly persons to have more enduring friendships, and show less interest in sex. They are also viewed as old-fashioned and rigid. A comprehensive review of the literature by McTavish (1971) reveals many specific stereotypic beliefs about the elderly. The public believes that old persons are generally ill, tired, forgetful, mentally slower, less able to learn new tasks and unproductive. They are also perceived as grouchy, unmotivated, disinterested in sex, isolated, withdrawn and

depressed. It is interesting to note similar attitudes and stereotypes among common people in more recent investigations (Brubaker & Power, 1976; Eisdorfer, 1975; Hess, 1974).

In conclusion, the elderly are constantly evaluated along many dimensions by various members of the society. These evaluations are mostly negative. There are many myths and stereotypes about old age and older persons. Perhaps the most damaging myth is that physical and mental capacities must show progressive deterioration as a result of the biological process of aging. It is natural that such unfavorable evaluations will make the elderly an unwelcome segment of the society. By and large, the public is least concerned with their quality of life.

The situation is best summarized by Skelton (1980):

> The attitudes and approaches of others towards the older individual largely dictate his or her self-image; this in turn determines the senior's attitude and behavior towards others. It must be remembered that one's attitude towards our elderly patients will have a great impact upon their prognosis and may greatly affect the outcome of treatment programmes (Skelton, 1980, p. 527).

Professional Attitudes

Since attitudes determine feelings and actions, it is important to examine the attitudes of all those who are associated with old persons in the planning, implementation and delivery of health care services. A diverse group of people ranging from general practitioners, psychiatrists, psychologists, social workers, nurses and administrators to aides, orderlies and cleaning staff are involved in the management of old persons within institutional settings. Their attitudes are reflected in the kind of care and management given to the elderly.

The attitudes of health care workers are likely to influence the self-esteem and self-worth of the aged (More, 1977). In fact, it is recognized that proper professional attitudes are essential in order to promote independence and self-sufficiency among older persons living in institutions. Even when an old person lives independently or with his family, he has to interact with physicians, lawyers and administrators of government agencies for a variety of services. Therefore, his personal approach to life and his ability to handle everyday problems will be influenced by the attitudes and opinions of these significant persons of the society. Brubaker and Powers (1976) have shown that self perception of the elderly has a significant effect on their mental health and behavior.

There is a conspicuous lack of studies concerning attitudes of professionals and paraprofessionals with respect to the aged. This deficiency is particularly noticeable in Canada where professional interest in gerontology and geriatric problems has started only recently. The problem of attitudes assumes greater significance in the training programmes for health care workers. Since health care workers come from the general population, they are likely to bring old attitudes and stereotypes about the elderly. Negative and patronizing attitudes will certainly hinder the effectiveness of service programs (Alfano, 1975; Futrell & Jones, 1977). Also, the geriatric patients are not likely to cooperate with the workers who possess biased attitudes toward them. Henry (1968) has noted the low level of interest in the elderly among therapists which makes it difficult to change the elderly.

In recent years, professional workers in the field of gerontology have become increasingly aware of the fact that the public has generally negative attitudes toward the elderly. Lack of public support for service facilities for the aged beyond the minimum required is believed to be primarily due to the public's negative attitudes. Similarly, negative professional attitudes may be responsible for the lack of appropriate treatment programmes for geriatric patients, even when necessary resources are available in the institution.

Negative professional attitudes toward the elderly can be traced back to Freud (1904) who believed that older persons are not suitable for psychoanalysis. Psychiatric disorders of the aged group were mainly diagnosed as "chronic brain syndrome" which was irreversible and could not be treated. In fact, these views are still prevalent among mental health professionals. Gibson (1970) observed that psychiatrists are still pessimistic about treatability of older persons. He studied 138 older patients over the age of 65 years who were in a private hospital for a period of three years or more. He found that although prognosis was considered poor in 80% of the cases, yet 60% of them were discharged from the hospital within 90 days. Finel (1978) found that 56% of the psychiatrists did not see any patients over age 65 in their practice and those who saw only 2% of their practice time was spent on the elderly patients. Busse and Pfeiffer (1973), and Butler (1973) also observed the same trend among psychiatrists. Dr. Gustave Gingeras (1976) has indicated that doctors often pay little attention to diseases in older patients because they believe them to be part of the normal process of aging.

The general belief held by professionals is that older people are incapable of change, therefore, it is a waste of time and community resources to rehabilitate and treat them. Medical work with the elderly is much less rewarding and provides little satisfaction (Butler, 1977, Busse & Pfeiffer, 1973). Gruber (1977) describes that medical care of aged patients in the United States is characterized by negativism, defeatism and professional antipathy. In response to a recent circular (Brooke, 1973), many psychiatrists-in-training indicated that they would rather emigrate than practice psychogeriatrics. Several reasons for the dislike of geriatric medicine were identified in a survey conducted by Gruber (1977). Most respondents felt that geriatric training was depressing, difficult, not challenging, less rewarding, less prestigeous and unpleasant then traditional training. Dr. Louis Lasagna identifies negative attitudes toward the aged as a major obstacle to optimal care of the elderly patients (Riley, Riley & Johnson, 1969). Solomon and Vickers (1977) explain that negative attitudes of health professionals are mainly responsible for the underavailability of services for the elderly. However, several studies suggest that negative attitudes of health professionals are over emphasized (Brubaker & Power, 1976, Seltzer, 1977; Seltzer & Atchley, 1971).

Solomon and Vicker (1977) examined the attitudes of medical students and staff working with the elderly in comparison with a control group. They did not find any differences in the attitudes of the two groups toward old people. The stereotypic attitudes were held in approximately the same proportion in all groups. However, differences were noted in the sub-groups. It was found that geriatric students had

more positive attitudes than students from other areas. Futrell and Jones (1977) in their survey of physicians, social workers and nurses found that physicians had a slightly positive overall view of older people. Thus, it is not completely accurate to make a general assumption that all medical professionals have negative attitudes toward aged patients. However, most studies do suggest that a large majority of professionals hold negative atittudes.

The stereotypic attitudes of the professionals are particularly detrimental to the mental health programmes and the availability of social services for the elderly. Stereotypes prevent understanding of the personal problems of the elderly patients (Alfano, 1975). Fletcher (1972) states that a majority of health problems of the elderly are disposed of by saying "what do you expect at your age?". Solomon and Vickers (1977) noted that the main effect of the stereotype which considers all old persons as belonging to a homogeneous group is that the doctors tend to use a standardized procedure for dealing with the problems of the elderly. Another tendency among medical professionals is to recommend nursing homes or other institutional and custodial care. Kosberg and Gorman (1975) found a correlation between the custodial care of the elderly in an institution and negative attitudes of administrative staff.

Attitudes of the Elderly

As noted earlier a large majority of people have negative attitudes toward old age and believe that aging causes a significant decline in the ability to make any meaningful contribution to the society. This

cultural norm is also reflected in the way in which older persons and old age are perceived by the elderly themselves. The ageist attitude of the community members appears to be responsible for the self-hatred and low self-esteem commonly found among aged persons (Brubaker & Power, 1976; Skelton, 1980).

Studies have shown that older persons who are under institutional care develop more negative views about themselves through constant interaction with staff members who, in general, hold de-personalizing attitudes toward the elderly (Solomon & Vickers, 1977). Romaniuk, Hayer and Romaniuk (1977) noted that negative staff expectations lead to "regressive behavior" among the elderly.

These findings suggest that negative attitudes toward old age and older people acquired in young age do not change much. Acceptance of negative views about old age and old people by the elderly themselves is a great hinderance in the development of adequate health care facilities. The attitudes of the elderly must change for healthy and productive old age. This can be achieved by providing them with an alternative model of the aged through education early in life (Brubaker & Powers, 1976).

Attitudes of Children and Youth

In order to gain a better understanding of the origin of negative attitudes toward old age and the elderly, the attitudes of children and young people must be examined. Several studies have indicated that negative attitudes toward old age and the elderly start early in life. Negative attitudes do not change significantly until late in adolescence.

Seefeldt et al. (1977) found that as soon as the child develops the concept of age, stereotypes about the elderly also develop.

Children show either strong negative or positive stereotypes. However, most studies indicate the presence of strong negative stereotypes about the elderly. Older persons are viewed as helpless; passive, mean, sad and bad by the children (Seefeldt et al., 1977, Specula, 1975; Thomas & Yamamoto, 1975).

The negative attitudes appear to originate from the dominant physical features of older people portrayed in children's books, such as grey hair, wrinkles, stooped posture and eyeglasses. These physical features are strongly rejected by children and youth (Seefeldt et al., 1977, Thomas & Yamamoto, 1975). Children seem to learn early in life that old age is negatively evaluated by the adult world, and therefore, it must be rejected.

The positive stereotypes that were observed by the children were very few and simple in nature (Seefeldt et al., 1977; Thomas & Yamamoto, 1975). One example was that old persons were sometimes viewed as nice and friendly. However, even those who had positive attitudes toward the elderly had negative views about growing old. These children were repulsed by the idea of grey hair, wrinkled skin, poor eye sight and other physical features associated with old age.

These positive and negative views about the aged acquired during early childhood remain relatively stable until late adolescence (Hickey & Kalish, 1968; Specula, 1973). Researchers have observed that the stereotypic views about old people tend to increase with age. Britton

and Britton (1971) found that stereotypes were dominent in adolescent years. It was further noted that children with grandparents also had a similar negative stereotypic image of old people. This is probably due to grandparents being identified with the family rather than with the concept of old (Kahana & Kahana, 1970).

A number of studies have considered the content of children's literature as a potential source and reinforcement for negative attitudes toward old age and the elderly. Ansello (1977) examined early childhood literature and found that older characters had "constricted roles and constrained behavior." As a result, the stereotype of the elderly as a non-creative and boring person emerged. Robin (1977) found that in elementary school textbooks, older characters appeared rarely, and if they did appear they were portrayed very superficially. The portrayal of grandparents in the literature was also limited, with well defined roles--baby sitters, guardians, or senile. However, grandparents were shown as having warm feelings toward their grandchildren regardless of their physical and mental health (Constant, 1977).

The literature designed for adolescents was examined by Peterson and Eden (1977) who concluded that:

> . . . adolescent literature tends to support the youth culture with the emphasis on strength, beauty and physical activity. There seem to be few characters who gain the respect of others through the use of their wisdom, insight and patience . . .. There seems to be little reason or value in being old or in having old persons present.

As discussed above, children and the young mainly hold negative attitudes toward old age and the elderly. Seefeldt et al. (1977) point

out that problems experienced by the elderly in their relationship with the rest of the society may be a direct result of the unwillingness of younger persons to accept older people. In order to lead a meaningful and peaceful life in old age, attitudes of children and young people need drastic modification. Several studies have shown that negative attitudes and stereotypes toward old age and older people can be modified through exposure to positive educational materials as well as more contact with older persons.

The Gerontological Research Instructional Program in Oregon as reported by Specula (1973) appears to be a most effective educational method for modifying the attitudes of children and adolescents. Introduction of educational materials on aging over a period of two years was shown to have significantly altered the negative attitudes in the direction of a more positive orientation. However, it was noted that post-high school students were considerably less susceptible to attitude change. This indicates the importance of early educational programmes for bringing any change in attitudes.

4. Community Development and the Elderly

In order to understand and appreciate the role of community development for the well-being of elderly members of the society, it is necessary to examine the concept and meaning of community development. One of the earliest attempts to define community development was made at the Cambridge Conference in 1948:

> A movement designed to promote better living for the whole community, with the active participation and if possible on the initiative of the community, but if this initiative is not forthcoming spontaneously, then by the use of techniques of arousing and stimulating it in order to secure its active and enthusiastic response to the movement (quoted in Mukerji, 1967, p. 1).

A more practical definition was accepted by the United Nations:

> . . . the process by which the efforts of the people themselves are united with those of governmental authorities to improve the economic, social and cultural conditions of communities, to integrate these communities into the life of the nation, and to enable them to contribute fully to national progress (quoted in Roberts, 1979, p. 178).

These definitions identify the different elements that are incorporated in the concept of community development. The primary objective of community development is promotion of comprehensive development of a community. Community development is a process by which people, government and various social institutions attempt to improve the economic, political, social and personal aspects of living in the community. There are two essential elements in this process: (a) initiative and participation of the people to improve their standard of living with available resources of the community, and (b) provision of technical and professional services to initiate social change. Thus, community development involves modification of the structure and functions of the social system and subsystems for the benefit of the larger society (Roberts, 1979). It also includes modification of attitudes, beliefs, values and norms of the society in order to produce long-term social change (Dunham, 1970). As Biddle (1966) suggests: "Community development would become the human phase of every improvement effort" (p. 12).

Since community development is an educational-motivation process (Roberts, 1979) and is concerned with development of the total community, it must concern itself with those who are segregated and rejected by the community, such as the elderly. Improvement in the quality of life of old people is essential for a balanced and harmonious community. This can be achieved by modifying the existing facilities available for the elderly as well as by utilizing more innovative ideas in developing adequate care and rehabilitation programmes. Proper utilization of current resources and creation of new resources for adequate mental health facilities for the older population should be the goal of community development agents. Thus, it is obvious that integration of the elderly in the mainstream of the society will be facilitated by the community development approach.

Hypotheses

Consistent with the purpose of this study as discussed above, two main hypotheses were formulated. Several related questions pertaining to demographic variables were also examined. The two major hypotheses tested in the study are given below:

1. The public prefers custodial care rather than community oriented services for the treatment and management of the psychologically disturbed aged.
2. There is a relationship between attitudes toward old persons and types of services preferred for the psychologically disturbed aged:

   (a) Those who have positive attitudes toward the elderly prefer community oriented services.

   (b) Those who have negative attitudes prefer custodial care.

In order to assess the role of various demographic factors in the preference for mental health services and current attitude toward the mentally disturbed elderly, the following two main questions were examined:

1. Is there a relationship between demographic variables such as social class, ethnic background, age, sex, education income etc. and the type of services preferred for the psychologically disturbed aged?
2. Is there a relationship between demographic variables and attitudes toward older persons?

III. METHOD

Subjects

The Population Laboratory of the Department of Sociology at the University of Alberta maintains an address list of houses in the city of Edmonton. Three hundred (300) households were randomly selected by the computer from this household list. A set of questionnaires was mailed to the 300 householders with the request that they return the completed questionnaires as soon as possible.

A total of 69 respondents returned the completed questionnaires which were used for the data analysis.

Instruments

The three instruments used in this study are described below.

1. Psychogeriatric Services Scale (PSS)

A new scale called the Psychogeriatric Services Scale (PSS) was constructed by the author for measuring the subject's preference for mental health services for the elderly (see Appendix A1). The scale consists of 54 statements--27 positive and 27 negative arranged randomly in the questionnaire. Negative statements for the same content area are included to control response bias in the respondents. Thus, the subject's preferences are measured in respect of 27 different services for the psychologically disturbed elderly (see Appendix A2). These 27 services represent four major areas of mental health service. They are: (1) Community Care Services, (2) Institutional Care Services, (3) Preventive Care Services, and (4) After Care Services. The number

of questions pertaining to each of the four services categories are different, because some of the areas allow for more services than others. The statements included in each of the four areas of mental health services are presented in Appendix A3.

The Psychogeriatric Service Scale is a Likert-type instrument with 7 response alternatives, namely, "Strongly Disagree", "Disagree", "Slightly Disagree", "Slightly Agree", "Agree", "Strongly Agree" (see Appendix A1). The scoring weights are 1, 2, 3, 5, 6, and 7 respectively. Those who do not select any of the six alternatives are given a score of 4.

The initial version of the Psychogeriatric Services Scale was administered to a second year Sociology class of 25 students at the University of Alberta. The Split-half reliability coefficient based on Pearson-Product Moment formula was found to be .70. The students were also requested to comment upon the individual items. On the basis of the comments obtained from students and other professionals working with old people, several modifications were made to construct the final scale as discussed above. The final version of the scale was used on the research sample of this study and has yielded a split-half reliability coefficient of .80. The equal length Spearman-Brown coefficient is .89, and Guttman Split-half Coefficients is .88. In addition, alpha for Part I is .84 and Part II is .93. The PSS is, therefore, a reliable instrument. Paired t-tests were performed to see whether the items pertaining to 27 services differed significantly from each other. As shown in Table 1, a large majority of the paired comparisons are significantly different. This indicates that the items are indeed meaning different types of services.

TABLE 1

Paired t-Tests of 27 Services

	Day Care Center 1	Day Hospitals 2	Special Mental Health Services 3	Community Mental Health Services 4	Home Visiting Psychiatric and Psych. Services 5	Mental Hospitals 6	Preventive Services 7	Counselling Services 8	Community Mental Health Center 9
1									
2	-1.93*								
3	-3.95*	-2.68**							
4	-0.84	1.13	3.52**						
5	1.25	3.10**	4.88**	2.11*					
6	-3.32**	-1.67	1.05	-2.83**	-4.03**				
7	-4.42**	-3.36**	-2.68	-4.32**	-5.74**	-1.58			
8	-1.67	0.114	2.82**	-1.22	-3.46**	1.50	3.19**		
9	0.558	2.35*	4.49**	1.66	-0,903	3.68**	5.45**	2.41*	
10	-3.68**	-2.19*	0.712	-3.13**	-5.31**	-0.548	1.13	-2.27*	-4.75**
11	-0.875	1.14	3.58	-0.479	1.97*	2.41*	3.77**	0.889	-1.34
12	0.975	2.57*	4.03**	1.54	-0.372	3.59**	4.59**	2.42*	0.625
13	-1.54	0.493	2.88**	-0.883	-2.78**	1.87	3.63**	0.429	-2.31*
14	-3.93	-2.41*	0.648*	-2.95**	-5.24**	-0.683	1.13	-2.20*	4.73**
15	0.943	2.51*	4.74**	2.02*	-0.374	3.96**	5.53**	2.81**	0.526
16	4.54**	7.09**	9.45**	5.11**	3.25**	7.11**	10.00**	7.03**	4.16**
17	4.19**	5.74**	7.59**	6.52**	2.83**	7.33**	8.20**	6.59**	4.74**
18	-3.23**	-1.69	1.00	-2.62*	-4.30**	-0.292	1.33	-1.97**	-4.05**
19	-2.65*	-0.929	1.94*	-1.96*	-4.58**	0.849	2.50*	-1.05	-3.64**
20	-2.25**	-0.531	1.98*	-1.58	-3.29**	1.007	3.00**	-0.609	-2.86**
21	-2.95**	-1.09	1.41	-2.27*	-4.07**	0.322	2.56*	-1.17	-3.58**
22	-2.77**	-0.573	1.94*	-1.98*	-3.48**	0.805	2.60*	-0.645	-4.06**
23	-2.83**	-1.177	1.48	-2.19*	-3.79**	0.353	2.39*	-1.19	-3.44**

TABLE 1 (continued)

	Day Care Center	Day Hospitals	Special Mental Health Services	Community Mental Health Services	Home Visiting Psychiatric and Psych. Services	Mental Hospitals	Preventive Services	Counselling Services	Community Mental Health Center
	1	2	3	4	5	6	7	8	9
24	-3.89**	-2.38*	0.299	-3.44**	4.73**	-0.908	0.689	-2.36*	-5.18**
25	0.423	1.82	4.31**	0.967	-1.16	2.95**	4.69**	2.02*	-0.533
26	0	1.85	4.33**	1.03	-1.43	3.39**	5.09**	1.90	-0.725
27	0.629	1.35	4.08**	0.135	-2.05*	2.55*	4.81**	1.25	-1.26

TABLE 1 (continued)

	Out-Reach Services 10	Sheltered Workshops 11	Psychogeriatric Units in Nursing Homes & Hospitals 12	Home Care 13	Mental Health Consultant 14	Half-Way Houses 15	Multipurpose Senior Citizen Centers 16	Alcohol and Drug Abuse Centers 17	Educational Programme 18
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11	3.02**								
12	3.80**	1.87							
13	2.64*	-5.02	-1.99*						
14	-7.68	-3.11**	-4.12**	-2.54*					
15	4.57**	1.76	-2.79	2.55*	4.36**				
16	8.51**	5.22**	2.86**	5.51**	8.78**	3.47**			
17	-0.76**	4.79**	2.37*	5.89**	7.19**	5.61**	-3.78		
18	0.292	-2.42*	-3.45**	-2.07*	0.358	-3.83**	-3.56**	-7.54**	
19	1.16	-1.94*	-3.51**	-1.41	1.35	-4.26**	-7.79**	-7.14**	1.32
20	1.46	-1.44	-2.84**	-0.896	1.71	-3.18**	-6.95**	-6.06**	1.35
21	1.11	-2.22*	-3.25**	-1.57	0.983	-4.13**	-7.12**	-7.10**	0.619
22	1.62	1.78	-2.83**	-1.26	1.48	-3.47**	-6.57**	-7.32**	1.12
23	1.02	-2.09*	-3.45**	-1.53	1.11	-3.57**	1.44**	-7.06	0.617

TABLE 1 (continued)

	Out-Reach Services	Sheltered Workshops	Psychogeriatric Units in Nursing Homes & Hospitals	Home Care	Mental Health Consultant	Half-Way Houses	Multipurpose Senior Citizen Centers	Alcohol and Drug Abuse Center	Educational Programme
	10	11	12	13	14	15	16	17	18
24	-3.48	-3.36**	-4.07**	-2.96**	-0.354	-4.51**	-9.34**	-7.37**	-0.599
25	3.56**	0.823	-0.993	1.48	3.56**	-0.852	-4.26	-4.63**	3.32**
26	3.91**	0.865	-1.07	1.74	3.96**	-1.09	-4.42**	-5.42**	3.41**
27	3.36**	0.192	-1.89	-0.677	3.64**	-1.73	-6.05**	-4.69**	3.43**

TABLE 1 (continued)

	Existing Mental Health Service	Psychiatric & Psych. Services in Nursing Homes & Hospitals	Improved Living Conditions	Improved Medicare	Mobile & Emergency Medical & Psychiatric Services	Recreation & Leisure Activities	Transportation Services	Information & Referral	Improvement in Institution
	19	20	21	22	23	24	25	26	27
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20	0.337								
21	-0.237	-0.575							
22	0.359	-0.109	0.548						
23	-0.433	-0.629	0	-0.531					

TABLE 1 (continued)

	Existing Mental Health Service	Psychiatric & Psych. Services in Nursing Homes & Hospitals	Improved Living Conditions	Improved Medicare	Mobile & Emergency Medical & Psychiatric Services	Recreation & Leisure Activities	Transportation Services	Information & Referral	Improvement in Institution
	19	20	21	22	23	24	25	26	27
24	-1.39	-1.68	-1.24	-1.66	-1.32				
25	2.75**	2.17*	2.74**	2.59*	3.35**	4.25**			
26	3.17**	2.28*	3.17**	2.96**	3.37**	4.68**	-0.645		
27	2.75**	1.90	2.52*	1.82	2.28*	3.62**	0.508	-0.696	

*p < 0.05

**p < 0.01

2. Old People Scale (OPS)

This scale was carefully constructed by Kogan in 1961 to measure attitudes toward old people. Items of this scale are concerned with (1) residential aspect of old people's lives, (2) vague feelings of discomfort and tension, (3) qualities of old people, and (4) interpersonal relationship across age generation. There are 17 positive and 17 negative statements about old people. The OPS is presented in Appendix B.

Kogan (1961) has reported reliability coefficients for the negative statements of the OPS scale as follows: .73 and .83 for the North Eastern University samples and .76 for the Boston University sample. The corresponding values for the positive statements were .66, .73, and .77 respectively. Thus, the OPS has high reliability coefficients.

In order to reexamine the reliability of this scale, a split-half correlation coefficient was computed on the data obtained from the present research. The present correlation coefficient is .61. The equal length Spearman-Brown Coefficient is .76 and Guttman Split-half Coefficient is .76. In addition, alpha for Part I is .69 and Part II is .66.

3. Demographic Information Questionnaire (DIQ)

A general questionnaire (see Appendix C) containing 21 questions was constructed for eliciting information about age, sex, education, occupation, income, social class, religion, ethnic background, etc. In addition, there are 7 questions pertaining to parents, grandparents, their living arrangements and the frequency of interpersonal contact

between the respondent and the parents or grandparents. This information was elicited to examine possible relationships between demographic variables, service orientation and attitude toward old persons.

Procedure

The three research instruments (PSS, OPS and DIQ) were mailed to the computer-selected random list of households in the city of Edmonton. A covering letter was addressed to the Head of the Household explaining the purpose and importance of the study. The covering letter as well the instructions for each questionnaire emphasized the fact that the responses were completely anonymous. A stamped and self-addressed envelope was enclosed for the return of the completed materials.

A total of 65 persons returned the questionnaire by the end of the second week of the original mailing date. During the third week, follow-up letters were sent to the first 150 subjects and telephone calls were made to the next 150 subjects from the respondents' list. By the end of the fourth week, 11 additional responses were received. In summary, a total of 79 subjects returned the materials. However, 7 sets of questionnaires were discarded, because they were either blank or filled inadequately. In addition, 3 sets of questionnaires could not be used as they arrived after the data had been analyzed.

Thus, 69 sets of questionnaires were used for data analysis. In terms of useable responses, the return rate was 23% which compares favorably with similar studies using the survey method (Selltiz et al., 1959).

Data Analysis

Responses of 69 subjects on PSS, OPS and DIQ instruments were transferred to "optical scanning" sheets for computer analyses. Using the SPSS programme, the data were analyzed for descriptive statistics (Mean, SD, Quartile, etc.), correlations and tests of significance. In order to test the hypotheses of this research, various statistical comparisons were made between PSS and OPS responses and their relationships with demographic variables were examined.

Item analysis of the PSS and OPS was done by the computer to check the internal validity and reliability of the instruments (see page 40).

IV. RESULTS

Before the results of the data analyses pertaining to the hypotheses are presented, it may be useful to look at the important personal characteristics of the respondents.

General Information About the Respondents

Table 2 presents the age, sex and marital status of the respondents. The subjects ranged in age from 18 to 81 years which ensures a wide coverage of the research population. The largest group of the respondents (32.4%) is in the range of 35 to 49 years followed by 50-64 years range (29.4%). The two smallest age groups are 18 to 24 years (5.9%) and 65-81 years (13.2%). The undersampling of the younger age group may be due to the fact that the younger recipients of the research material were not interested in the study and consequently did not return the completed questionnaires. As for the older group (65 years and over), the low response rate may be either because older persons were not heads of the household or were living in nursing homes so that they did not receive the questionnaires. It is satisfying to note that about 81% of the respondents fall in 25-64 years age range which is representative of the general population.

With respect to the sex of the respondents, about 61% are females and 39% are males. The majority of the respondents (76.8%) are married, and the rest are either single, widowed, separated or divorced.

Other demographic characteristics such as religion, ethnic background and education are given in Table 3. With regard to religious

TABLE 2

Age, Sex and Marital Status

of the Respondents

GROUPS		NO.	%
Age		(N = 68)	
	18 - 24	4	5.88
	25 - 34	13	19.12
	35 - 49	22	32.35
	50 - 64	20	29.41
	65 - 81	9	13.24
Sex		(N = 69)	
	Male	27	39.13
	Female	42	60.87
Marital Status		(N = 69)	
	Single	6	8.70
	Widowed	6	8.70
	Married	53	76.81
	Separated	2	2.90
	Divorced	2	2.90

background, approximately 15% of the respondents did not reveal their religious believes. However, among 59 respondents who give information about their religion, a vast majority (94.9%) are Christians. The Christians are further subdivided into 44.1% as Protestants, 22% as Catholics, and 28.8% as other specified denominations. Very few respondents (3.4%) are non-Christians.

Ethnic backgrounds of the respondents appear to be fairly representative of the Edmonton population. About 45% of the subjects have European background, whereas about 39% identify themselves as having Canadian origin. These respondents are most likely second generation Canadians. The research sample also has 16.4% of the subjects from other ethnic backgrounds. A wide range of educational levels is found among the respondents. A large percentage (58.8%) of the respondents have either university of technical education. About 41% of the sample have high school education or less.

Table 4 shows the employment status, occupation and income of the respondents. Sixty four per cent of the respondents are employed, 14% are unemployed, about 19% are retired and 3% are students. It should be noted that 5 persons did not reveal their employment status. With respect to occupation, there is an oversampling of white collar occupations which constitute about 77% of the research sample. Only 14% are blue collar workers, and 9% are housewives. Since most of the respondents are females, the white collar group is likely to include a considerable number of women.

TABLE 3

Religion, Ethnic Background and

Education of the Respondents

GROUPS	NO.	%
Religion	(N = 59)	
Protestants	26	44.07
Catholics	13	22.03
Other Christian Denominations	17	28.81
Eastern	2	3.39
No Religion	1	1.69
Ethnic Background	(N = 67)	
European	30	44.78
Native Canadian	26	38.81
Other	11	16.42
Education	(N = 68)	
Grade - 1-6	4	5.88
7-12	24	35.29
University - 1-8 years	28	41.18
Voc./Tech. - 1-4 years	12	17.65

TABLE 4

Employment Status, Occupation and

Income of the Respondents

GROUPS	NO.	%
Employment Status	(N = 64)	
Employed	41	64.06
Unemployed	9	14.06
Retired	12	18.75
Student	2	3.13
Occupation	(N = 64)	
White Collar	49	76.56
Blue Collar	9	14.06
Housewife	6	9.38
Income	(N = 63)	
$5,000 - 15,000	15	23.81
$15,001 - 30,000	19	30.16
$30,001 - 45,000	17	26.98
$45,001 +	12	19.05

Income of the respondents is distributed across a wide range. About 24% are in the $5,000 - $15,000 range, 30% in the $15,001 - $30,000 range, 27% in the $30,000 to $45,000 range, and 19% in the range of $45,001 and over. This distribution appears to be consistent with the income distribution of the general population in Edmonton.

Hypothesis 1: The public prefers custodial care rather than community oriented services for the treatment and management of the psychologically disturbed aged.

The first hypothesis was concerned with the type of mental health services for the elderly preferred by the community members. It was hypothesized that the public prefers custodial care rather than community-oriented services for the treatment and management of the psychologically disturbed elderly. In order to test this hypothesis, responses on the Psychogeriatric Services Scale (PSS) are analyzed for relevant information.

As mentioned in the 'Instruments' section (see page 40), each question of the PSS is scored on a 7-point scale. Negative preferance or attitude is reflected in scores of 3 or lower on each item of the scale. Similarly, positive attitude is manifested in scores of 5 or over on each item of the scale. Thus, for all items of the PSS, any score in the range of 54 to 162 is considered as representing definite "Custodial orientation", and any score in the range of 270-378 is regarded as reflecting definite "Community orientation" (see Table 5). Moreover, for both categories, strength of the preference is indicated by higher scores. That is, the higher the score within the custodial

TABLE 5

Response Categories for PSs and OPS

	GROUP	SCORE RANGE*
Psychogeriatric Services Scale (PSS)	Custodial Care	54 - 162
	Community Care	207 - 378
Old People Scale (OPS)	Negative Attitude	34 - 102
	Positive Attitude	170 - 238

* The score ranges given in this table are based upon the following weights for each item on both the tests.

(a) Custodial Care and Negative Attitude - 1-3

(b) Community Care and Positive Attitude - 5-7

or community orientation categories, the stronger is the attitude for custodial care or community services. Thus, for the community orientation category, scores falling below 324 are considered as low community orientation, and scores falling above 324 are considered high community orientation.

The descriptive statistics for the scores on the PSS are given in Table 6. All scores range from 211 to 362 with a mean of 307.27 and SD of 32.11. As indicated by the quartile points, 25% scores fall below 286 and 75% below 332. Although the frequency distribution is normal, the high Standard deviation suggests a large dispersion of the scores around the mean.

According to the scoring criteria for service orientation used in this study, no respondent has revealed custodial orientation. Approximately 90% subjects demonstrate community orientation of mental health services for the elderly. The remaining 10% subjects express neutral attitudes. However, when we analyze the range of scores within the community orientation category, we find 63% of the respondents as having low community orientation, whereas 27% have high community orientation (see Table 7). This shows that only a small percentage of the subjects have a strong preference for community orientation in mental health services for the aged.

In order to assess the service orientation of the subjects, the data are further analyzed by dividing the items of the Psychogeriatric Scale (PSS) into 4 groups of services: 1) Preventive Care, 2) Community Care, 3) Improved Institutional Care, and After Care

TABLE 6

Descriptive Statistics for

Psychogeriatric Services Scale (PSS)

SCORE	f (N=67)	%		
211	2	3	Minimum - 211	Q1 = 289
231	2	3		
251	3	4.5	Maximum - 362	Q2 = 306
271	9	13.4		
291	20	29.9	Mean - 307.27	Q3 = 332
311	13	19.4		
331	13	19.4	Standard Deviation - 32.11	
351	5	7.5		

TABLE 7

Comparison of High and Low Groups for the PSS and the OPS Scores

	GROUP	SCORE RANGE	f	%	TEST OF SIGNIFICANCE
Psychogeriatric Services Scale (PSS) N = 67	High Community Orientation	325-362	18	27.87	$X^2 = 9.6$, df = 1 $p < 0.01$
	Low Community Orientation	270-323	42	62.69	
Old People Scale (OPS) N - 68	High Positive Attitude	193-214	16	23.53	$X^2 = 3.28$, df = 1 $p > .05 < 0.10$
	Low Positive Attitude	170-192	28	41.18	

(see Appendix A3 for the items in each category). Each person's responses were separated into the above-mentioned four categories. Table 8 gives mean and standard deviation and Table 9 gives analysis of variance of the data for the four groups of services. The highest preference is for the Preventive Care Services followed by Improved Institutional Care, Community Care and After Care. The ANOVA is a little over .05 level of significance (see Table 9), however, the Duncan's test shows significant differences between the groups at .05 level.

Although findings of this study do not confirm the first hypothesis completely, the data are, however, in the predicted direction. In general, more people have low community orientation.

Hypothesis 2: There is a relationship between attitudes toward old persons and types of services preferred for the psychologically disturbed aged:

(a) Those who have positive attitudes toward the elderly prefer community oriented services.

(b) Those who have negative attitudes prefer custodial care.

The second hypothesis was concerned with the nature of relationships between attitudes toward old persons and type of services preferred for the psychologically disturbed aged. Specifically, it was predicted that those with positive attitudes toward the elderly would prefer community oriented services, while those who have negative attitudes would prefer custodial care.

TABLE 8

Comparison of Four Groups of Services

GROUP (N = 69)	MEAN	SD
1. Preventive Care	5.79	0.62
2. Institutional Care	5.74	0.68
3. Community Care	5.56	0.72
4. After Care	5.49	0.89
TOTAL	5.64	0.74

TABLE 9

Analysis of Variance of

Four Groups of Services

SOURCE OF VARIATION	SUM OF SQUARES	df	MEAN SQUARES	F	p
Between Groups	4.0724	3	1.36	2.528	0.577
Within Groups	146.0350	272	0.54		
TOTAL	150.11	275			

The respondents are defined as having positive and negative attitudes on the basis of their obtained scores on the Old People Scale (OPS). Scores falling in the range of 34 to 102 indicate a definite negative attitude and scores in the range of 170 to 238 are considered as an expression of a definite positive attitude (see Table 5). The rationale for the categorization of positive and negative attitudes is similar to the one used for PSS (see page 55).

The descriptive statistics for the OPS are given in Table 10. These scores vary within a much smaller range than is the case with PSS scores. Apparently, the respondents are more similar in their attitudes toward old persons. In terms of the scoring criteria for positive and negative attitudes, none of the subjects has definite negative attitudes. There are 64.7% persons in the sample who show clear-cut positive attitudes. The remaining 35.3% may be considered as holding neutral attitude toward old persons. Since the majority of the respondents have positive attitudes, this category is further divided into high positive attitude and low positive attitude in order to compare the strength of the attitude. Those scoring between 170 and 192 are considered by the researcher to have a low positive attitude and those scoring above 192 have a high positive attitude. Using this classification system, 41% respondents reveal a low positive attitude and 23% a high positive attitude (see Table 7). Thus, consistent with the previously mentioned result, most respondents have a low positive attitude.

Hypothesis 2 was tested directly by crosstabulating the high

TABLE 10

Descriptive Statistics for

Old People Scale (OPS)

SCORE	f (N = 68)	%		
136	5	7.4	Minimum - 136	Q1 = 165
146	2	2.9		
156	10	14.7	Maximum - 214	Q2 = 179
166	11	16.2		
176	10	14.7	Mean - 178.34	Q3 = 191
186	19	27.9		
196	9	13.2	Standard Deviation - 17.28	
206	2	2.9		

and low scores on both PS and OP scales (see Table 11). Although the differences are not statistically significant, the trend is in the predicted direction ($X^2 = 2.39$, $df = 1$, $p < 0.07$). Another way of testing this hypothesis is to examine the relationship between scores on the PS and OP scales. The Pearson product-moment correlation coefficient between the two scales is 0.38 which is significant at the 0.001 level. Although there is a positive correlation between attitudes toward old persons and preference for community mental health services for the elderly, the strength of the relationship is not very high. Thus, precise prediction of a person's service orientation is not possible from the knowledge of his/her attitude towards the elderly.

Another part of the second hypothesis predicts preference for custodial care among those who hold negative attitudes toward old persons. However, this hypothesis is not relevant since the respondents show neither negative attitude nor custodial orientation.

In general, the second hypothesis may be considered as confirmed.

Demographic Variables

The nature of relationship demographic variables have with service orientation and attitudes toward old people is analyzed in terms of correlation coefficients. From the matrix of intercorrelations between all items of the PSS, the OPS and the Demographic Information Questionnaire, a list of only significant correlations has been prepared (see Table 12). It is apparent that most demographic

TABLE 11

Crosstabulation of High and Low Scores

on PS and OP Scales

		OPS			
		HIGH	LOW	TOTAL	TEST OF SIGNIFICANCE
PSS	HIGH	19	14	33	$X^2 = 2.39$
					df = 1
					$p < 0.07$
	LOW	13	23	36	
	TOTAL	32	37	69	

TABLE 12

Significant Correlation Coefficients Between

Demographic Variables and PSS and OPS Scales

DEMOGRAPHIC VARIABLES	PSS SCORE	p	OPS SCORE	p
Marital Status	---	---	0.30	0.007
Immigration Year	0.46	0.038	0.53	0.017
Education	0.21	0.049	---	---
Occupation	---	---	-0.26	0.029
Income	0.22	0.042	---	---
Mother Living	-0.21	0.046	-0.23	0.034

variables are not related to either type of mental health services preferred for the psychologically disturbed elderly or to attitudes toward old persons. Surprisingly, of all the demographic variables, Immigration Year correlates .46 with PSS and .53 with OPS. This suggests that recent immigrants to Canada have positive attitudes toward old persons as well as they prefer community services for the disturbed elderly. Another interesting observation is the negative correlation between Mother Living and PSS (-.21) and OPS (-.23). Thus, those whose mothers are alive tend to have low community orientation and have negative attitude toward old persons.

The influence of demographic variables on PSS and OPS scores can also be examined through mean score differences. Tables 13 to 17 give frequencies, percentages, means and standard deviations of various demographic groups on the PSS. These mean differences are, however, not significant statistically. Similar analyses have been done of the scores of various demographic groups on the OPS (see Tables 18 to 21). The mean differences are, again, not significant statistically.

A further analysis is made by dichotomizing each demographic variable into high and low scoring groups on the PS and OP scales. The purpose of this analysis is to see whether the two groups differ significantly in their preference for services and attitudes toward old people. The Chi Square tests do not reveal significant differences for any demographic variable.

Thus, most demographic variables do not seem to have any important relationship with the PSS and the OPS scores.

Also, the demographic variables do not produce any differences in either the PSS or OPS scores.

TABLE 13

Frequencies, Percentages, Means and SDs of the PSS Scores by Age, Sex and Marital Status

GROUP	NO. (N = 66)	%	PSS SCORE MEAN	SD
Age				
18 - 24	4	6.06	287.50	51.76
25 - 34	13	19.70	320.92	19.72
35 - 49	22	33.33	304.22	26.86
50 - 64	19	28.79	316.10	33.09
65 - 81	8	12.12	286.87	38.18
Sex	(N = 67)			
Male	27	40.30	299.52	33.25
Female	40	59.70	312.50	30.63
Marital Status	(N = 67)			
Single	6	8.96	296.67	44.03
Widowed	6	8.96	307.67	16.38
Married	51	76.12	327.00	32.26
Separated	2	2.99	307.16	32.76
Divorced	2	2.99	321.00	21.22

TABLE 14

Frequencies, Percentages, Means and SDs of the PSS Scores by Education and Ethnic Background

GROUP	NO. (N = 67)	%	PSS SCORE MEAN	SD
Education				
Grade - 1-6	4	5.97	316.25	30.72
7-12	24	35.82	299.63	32.93
University				
1-8 years	27	40.30	311.93	29.49
Voc/Tech.				
1-4 years	12	17.91	309.09	37.31
Ethnic Background	(N = 67)			
European	30	44.78	306.80	31.49
Native Canadian	26	38.81	311.69	25.98
Other	11	16.42	310.89	38.84

TABLE 15

Frequencies, Percentages, Means and SDs of the

PSS Scores by Religion

GROUP	NO. (N = 59)	%	PSS SCORE MEAN	SD
Religion				
Protestant	26	44.07	303.58	38.94
Orthodox	1	1.70	238.00	0.0
Baptist	5	8.47	303.60	40.17
Catholic	13	22.03	311.62	21.93
Mormon	1	1.70	322.00	0.00
Anglican	3	5.08	321.00	13.46
United	3	5.08	276.00	19.00
Lutheran	1	1.70	274.00	0.00
Presbyterian	1	1.70	331.00	0.00
Other Christian	2	3.39	333.50	21.51
Eastern	2	3.39	335.00	4.25
None	1	1.70	286.00	0.00

TABLE 16

Frequencies, Percentages, Means and SDs of the PSS Scores by Religion

GROUP	NO. (N = 53)	%	PSS SCORE MEAN	SD
Occupation				
Managerial	6	11.32	296.33	38.20
Teaching	14	26.41	316.64	20.34
Medicine & Health	6	11.32	315.83	33.36
Clerical	9	16.98	319.11	29.24
Sales	3	5.66	292.67	45.65
Machine Related	1	1.89	322.00	0.00
Construction	2	3.77	301.50	6.36
Transport	3	5.66	314.00	24.58
Housewife	6	11.32	298.00	19.65
Service Occupation	1	1.89	303.00	0.00
Material Handling	1	1.89	211.00	0.00
Other	1	1.89	316.00	0.00

TABLE 17

Frequencies, Percentages, Means and SDs of the

PSS Scores by Income

GROUP		NO. (N = 62)	%	PSS SCORE MEAN	SD
Income					
	Under $5,000	5	8.06	327.80	30.97
	$5,000 - $10,000	4	6.45	290.75	55.05
	$10,001 - $15,000	6	9.58	296.50	33.96
	$15,001 - $20,000	4	6.45	304.25	19.53
	$20,001 - $25,000	7	11.29	310.00	25.63
	$25,001 - $30,000	8	12.90	313.63	42.39
	$30,001 - $35,000	12	19.35	309.83	30.46
	$35,001 - $40,000	0	0	0	0
	$40,001 - $45,000	4	6.45	332.75	13.94
	$45,001 +	12	19.36	306.75	22.44

TABLE 18

Frequencies, Percentages, Means and SDs of the

OPS Scores by Age, Sex and Marital Status

GROUP	NO. (N = 68)	%	OPS SCORE MEAN	SD
Age				
18 - 24	4	5.88	170.00	11.16
25 - 34	13	19.12	183.46	11.67
35 - 49	22	32.35	178.18	15.45
50 - 64	20	29.41	182.80	19.67
65 - 81	9	13.24	163.50	20.25
Sex	(N = 69)			
Male	27	39.13	174.82	16.64
Female	42	60.87	180.66	17.50
Marital Status	(N = 68)			
Single	6	8.82	170.83	9.62
Widowed	6	8.82	162.83	19.31
Married	52	76.47	180.04	16.99
Separated	2	2.94	183.50	12.02
Divorced	2	2.94	198.00	7.07

TABLE 19

Frequencies, Percentages, Means and SDs of the OPS Scores by Education and Ethnic Background

GROUP	NO. (N = 68)	%	OPS SCORE MEAN	SD
Education				
Grade - 1-6	4	5.88	178.75	29.06
7-12	25	36.76	176.48	18.97
University				
1-8 years	27	39.71	180.67	13.48
Voc./Tech.				
1-4 years	12	17.65	176.83	18.73
Ethnic Background	(N = 66)			
European	30	45.45	176.83	16.46
Native Canadian	26	39.39	178.46	18.70
Other	10	15.15	185.30	16.56

TABLE 20

Frequencies, Percentages, Means and SDs of the

OPS Scores by Religion

GROUP	NO. (N = 60)	%	OPS SCORE MEAN	SD
Religion				
Protestant	27	45.00	181.59	16.40
Orthodox	1	1.67	158.00	0.0
Baptist	5	8.33	189.60	11.06
Catholic	13	21.67	173.54	22.99
Mormon	1	1.67	186.00	0.0
Anglican	3	5.00	175.33	20.31
United	3	5.00	170.33	6.66
Lutheran	1	1.67	176.00	0.00
Presbyterian	1	1.67	184.00	0.00
Other Christian	2	3.33	191.50	0.71
Eastern	2	3.33	173.50	13.44
None	1	1.67	145.00	0.00

TABLE 21

Frequencies, Percentages, Means and SDs of the

OPS Scores by Occupation

GROUP	NO. (N = 54)	%	OPS SCORE MEAN	SD
Occupation				
Managerial	6	11.11	175.50	13.49
Teaching	14	25.93	182.22	11.45
Medicine & Health	6	11.11	186.17	17.26
Clerical	9	16.67	177.22	17.61
Sales	4	7.41	184.50	18.23
Machine Related	1	1.85	171.00	0.0
Construction	2	3.70	191.00	2.83
Transport	3	5.56	186.00	33.96
Housewife	6	11.11	176.67	19.42
Service Occupation	1	1.85	145.00	0.0
Material Handling	1	1.85	169.00	0.0
Other	1	1.85	163.00	0.0

TABLE 22

Frequencies, Percentages, Means and SDs of the OPS Scores by Income

GROUP	NO. (N = 63)	%	OPS SCORE MEAN	SD
Income				
Under $5,000	5	7.49	173.00	28.61
$5,000 - $10,000	4	6.35	176.50	11.73
$10,001 - $15,000	6	9.52	176.50	24.85
$15,001 - $20,000	4	6.35	164.50	29.51
$20,001 - $25,000	7	11.11	181.57	10.45
$25,001 - $30,000	8	12.70	178.00	15.95
$30,001 - $35,000	12	19.05	176.83	16.35
$35,001 - $40,000	1	1.59	197.00	0.0
$40,001 - $45,000	4	6.35	184.50	22.31
$45,001 +	12	19.05	184.08	9.80

V. DISCUSSION AND CONCLUSION

The results of this study do not provide direct confirmation of the hypothesis that the public prefers custodial care rather than community oriented services for the psychologically disturbed elderly. In fact, not a single respondent has shown definite and clear-cut preference for custodial care as measured by the Psychogeriatric Services Scale (PSS). Since this preference scale has high reliability, the subjects' responses may be considered as dependable indicators of their preference pattern. The general belief held by many authors that the society accepts the "storage bin" philosophy which encourages "maintenance" rather than "rehabilitation" (e.g., Butler & Busse, 1977; Harrington, 1962) of the elderly does not seem to be supported by the present study.

However, a closer examination of the results suggests that the respondents' preferences are in the predicted direction. When all the community oriented scores are dichotomized into High and Low categories, we do find significant differences between the groups. A much larger percentage of the subjects have a low community orientation. Thus, people do not seem to have strong preference for community oriented mental health services for the elderly. This finding may be construed as supporting the first hypothesis indirectly.

Analysis of the data in terms of responses to preventive care, community care, improved institutional care and after care items on the PS scale provides a more precise assessment of the subjects' service orientation. Although preventive service is preferred most, it is

interesting to note that improved institutional care is preferred significantly more than community care and after care. This finding suggests that although the respondents do not prefer custodial care for the psychologically disturbed elderly, they would rather see them treated and managed in improved institutional settings. In a sense, such an orientation is a manifestation of less faith in community services for the treatment and management of the psychologically impaired elderly. The fact that after care services are preferred least is a further evidence of the tendency toward preference for institutional care of the aged. The results of the present research related to the preference for specific types of services are similar to the findings of other research reported in the literature. The importance and effectiveness of preventive care facilities for rehabilitating the aged have been demonstrated by Anderson (1974, 1975), Todd, (1968), etc. Similarly, beneficial results have been noted with improved institutional care (eg. Lawton & Gottman, 1974; Williams et al., 1970; Zarit, 1980; Stotsky, 1977; etc.).

Several other reasons may explain why the first hypothesis has not been confirmed directly. First it appears that only those who were highly concerned about the care facilities for the elderly and had positive attitudes toward them actually returned the questionnaires. This was also apparent in the comments of the subjects who were reminded through telephone calls to fill out the questionnaires and return them to the researcher. A large number of people simply said that they would not complete the questionnaires as they did not have any interest

in old persons. The research sample, therefore, may include very few respondents who hold negative attitudes toward the aged and who have custodial orientation for the treatment of psychological problems.

Second, it is possible that those who returned the questionnaires were sophisticated enough to understand the negative connotations of a custodial orientation. Hence, even though they may truly have a custodial orientation, they may have made an effort to appear community oriented in order to conform to the socially accepted preference pattern. That is why a vast majority of the subjects fall in the low community orientation category.

Third , the North American public, particularly in metropolitan centers are becoming increasingly aware of the problems faced by the elderly population. Growing interest in gerontology among researchers, government officials, politicans and professionals seems to have produced the desired positive effects on the public. Thus in urban centers like Edmonton, the public is changing toward community oriented services for the psychologically disturbed elderly.

Finally, the mental health movement which emphasizes community orientation in the treatment of mentally ill persons may be responsible for changing public attitudes toward the psychologically disturbed aged as well. Perhaps the public now does not have much faith in the usefulness of custodial care.

The second hypothesis asserted that there is a relationship between attitude toward the elderly and the type of services preferred for the psychologically disturbed aged. The prediction was

that people who have positive attitudes toward the elderly will prefer community oriented services and those with negative attitudes will prefer custodial care. Again, results of this study do not provide complete support for the second hypothesis. As shown in Table 9, although the tendency is present in the data, a high positive attitude toward old persons does not necessarily mean preference for community oriented services and vice versa.

Moreover, the relationship between attitude toward the elderly and type of services preferred for the aged is only moderate ($r = .38$), but highly significant ($p < 0.001$). This suggests that there is a positive correlation between attitude toward old persons and preference for services, although the strength of the relationship is not very high. The absence of strong correlation between attitude toward the elderly and preference for services indicates that high community orientation for services is not necessarily dependent upon positive attitudes. A person can have low positive or neutral attitude toward old persons, yet may prefer preventive or improved institutional services rather than custodial care for the aged. Another reason for low correlation between PSS and OP scales may be related to the variability of the distribution of scores. Statistically, the greater the variability, the greater is the correlation coefficient. Since there are no scores in the custodial orientation range on the PSS and in the negative attitude range on the OPS, the range of scores on both the variables is restricted. This may have produced small correlation coefficient between PSS and OPS. Thus, a more definite answer to the issue raised by the second hypothesis can

come only when we have responses from a more variable group.

The primary reason for the lack of complete confirmation of the second hypothesis appears to be the selective nature of the research sample. As mentioned before perhaps only those subjects returned the questionnaires who hold positive attitudes toward old persons as well as prefer community oriented services for the disturbed elderly. The results show clearly that no respondent has negative attitude toward old persons as measured by the OP Scale. Although 41% of the respondents have low positive attitude compared to 23% with high positive attitude, the Chi Square test does not reveal significant difference at the conventional .05 level. However, the two groups are significantly different at less than .10 level (see Table 9). In other words, a large percentage of the respondents have a low positive attitude toward old persons.

The findings of this study demonstrate only moderate relationships between some demographic variables, preference for services and attitude scores (see Table 11). The most substantial correlation is between Immigration Year and service orientation ($r = .46$), and between Immigration Year and attitude toward old persons ($r = .53$). New immigrants to Canada are more favorable toward older persons and prefer community services. If we view old people as handicapped or disadvantaged persons, then it is expected that the recent immigrants will empathize with the problems of the aged. Income is another variable which has a significant but small positive relationship with PS scores only. Apparently, higher income has the effect of making people more community oriented insofar as mental health services are concerned, although it does not have any effect on their attitudes toward old persons.

Perhaps the most interesting observation is the presence of small negative relationship between Mother Living and PSS ($r = -.21$) as well as OPS ($r = -.23$) scores. It appears that close personal contact with old persons is likely to engender negative and custodial orientation for services. Occupation and university education are also associated to a some extent with PSS and OPS scores (see Table 11). However, not much importance can be attached to these relationships, because the correlation coefficients are extremely small ($r = -.26$ and .21), although significant. These low correlation coefficients, therefore, suggest that preference for services and attitudes toward old persons cannot be predicted from most of the demographic variables.

It should be noted that the findings of the present study with respect to age are different from other research. For example, Haile (1979) found negative attitudes among students under 20 years of age compared to those who were in the 20-29 year group. Similarly, negative attitudes toward the aged among younger people are reported by Suedfelt (1977) who selected his sample from Vancouver, British Columbia. Insofar as other demographic variables such as sex, educational level or marital status are concerned, the results of the present study support other research findings (eg. Haile, 1979).

In spite of the usual limitations of survey research, the present study has several important implications for the mental health of the elderly. The results show that the public generally prefers community oriented services for the treatment, management and rehabilitation of the psychologically disturbed elderly. However, community mental health services are not preferred as much as preventive and modified institutional services are. This information is useful to community development workers, government planners and professionals for developing mental health programmes for the aged. Thus, preventive and improved institutional care services may be started first to be followed by other community oriented services.

The typical argument for inadequate government funding and professional apathy for mental health needs of the aged has been the lack of public support for such programmes. The present research, however, refutes this argument and demonstrates clearly the existence of public support for community oriented services. Nevertheless, there still appears to be a need for public education or the utilization of some other community development method, since the majority of the respondents have low community orientation. Strong public support for community mental health programmes is necessary for increased funding and allocation of relevant professional resources.

As for the attitude toward old persons, most people have low positive attitudes. This result is consistent with the findings discussed before. Again, it is a challenge to community development

experts and workers to initiate change in the public attitude toward old persons from low positive to high positive.

Perhaps the most important result of the present research is the fact that attitude toward old persons and preference for particular types of service are not associated strongly. Thus, even if the public is not strongly favorable toward the elderly, it can still support the development of community oriented services for the disturbed aged.

REFERENCES

Alfano, G. J. There are no routine patients. American Journal of Nursing, October 1975, 1804-1807.

Anderson, W. F. Community medicine and geriatrics. Public Health, 89, 55-56.

Ansello, E. F. Old age and literature: An overview. Educational Gernotology, 1977, 2(3), 211-218.

Atchley, R. A. The social forces in later life: An introduction to social gerontology. Belmont, Calif.: Wadsworth, 1972.

Baker, R. C., and Baker, L. S. The psychological ecology of old people in Midwest, Kanas, and Yoredal, Yorkshire. In B. L. Neugarten (Ed.), Middle age and aging: A reader in social psychology. Chicago: University of Chicago Press, 1968.

Baker, A. A., & Byrne, R. J. F. Another style of psychogeriatric service. British Journal of Psychology, 1977, 130, 123-126.

Baltes, P. B., and Danish, S. J. Intervention in life-span development and aging: Issue and concepts. In R. R. Turner and H. W. Reese (Eds.), Lifespan developmental psychology. New York: Academic Press, 1978.

Barraclough, B., Bunch, J., Nelson, B., & Sainsbury, P. A hundred cases of suicide: Clinical aspects. British Journal of Psychiatry. 1974, 125, 355-373.

Bataden, P. B. Working with older people: Biological, psychological and sociological aspects of aging. (vol. 2). DHEW Publication No. HRA74-3117, formerly HSM72-6006. Public Health Service Publication No. 1459 (vol. 2). Washington, D.C.: Government Printing Office, 1974.

Bengston, V. L. Inter-age perceptions and the generation gap. The Gerontologist, Winter 1971, Part II, 85-86.

Bennett, A. E. Psychiatric management of geriatric depressive disorders. Diseases of the Nervous System, 1973, 34, 222-225.

Berezin, M. A., & Stotsky, B. A. The geriatric patient. In H. Grumebaun (Ed.), The practice of community mental health. Boston, Mass.: Little Brown & Company 1970.

Bergman, K. In J. C. Howells (Ed.), Modern perspectives in the psychiatry of old age. New York: Brunner/Mazel, 1975.

Biddle, W. W. The "fuzziness" of definition of community development. Community Development Journal, 1966, 2, 12.

Birren, J. E., & Sloane, R. B. Manpower and training needs in mental health and illness of the aging. University of Southern California, Los Angeles, 1977.

Birren, J. E., & Sloane, R. B. (Eds.). Handbook of mental health and aging. Englewood Cliffs, N.J.: Prentice-Hall Inc., 1980.

Bock, E. W., & Webber, I. L. Social states and the relationship system of elderly suicides. Life-Threatening Behavior, 1972, 2, 145-159.

Bringman, W., & G. Rieder. Stereotyped attitudes toward the aged in West Germany and the United States. Journal of Social Psychology, 1968, 76, 267-268.

Britton, J. O., & J. H. Britton. Young people's perceptions of age and aging. The Gerontologist, 1970, 10(3), Part II, 39.

Brocklehurst, J. C., (Ed.). Textbook of Geriatric Medicine and Gerontology: London: Churchill Livingstone, 1973.

Brody, S. J. Comprehensive health care for the elderly. The Gerontologist, 1973, 13(4), 412-418.

Brooke, P. Psychiatrists in training. British Journal of Psychiatry, 1973, Special Publication No. 7.

Brubaker, T. H., & Powers, E. A. The stereotype of old: A review and alternative approach. Journal of Gerontology, 1976, 31(4): 441-447.

Busse, E. W., & Pfeiffer, E. (Eds.). Mental illness in later life. Washington D.C.: American Psychiatric Association, 1973.

Butler, R. N. Why survive? Being old in America. New York: Harper and Row, 1975.

Butler, R. N., & Lewis, M. I. Aging and mental health (2nd ed.). Saint Louis, Missouri: C. V. Mosby, 1977.

Carpenter, W. T. Jr. Current diagnostic concepts in schizophrenia. American Journal of Psychiatry, 1976, 133, 172-177.

Ciompi, L. G. Psychiatric literature in the postwar period. U.S. Department of Health, Education & Welfare. National Institute of Mental Health, Public Health Service, 1965.

Cohen, D. G. Mental health services and the elderly: Needs and options. American Journal of Psychiatry, 1976 133(1), 65-66.

Connor, C., & Walsh, R. P. Using attribution to assess attitudes toward the old. Paper presented to the 30th Annual Meeting of the Gerontological Society, San Francisco, November 1977.

Constant, H. The image of grandparents in children's literature. Language Arts, 1977, 54(1), 33-40.

Daniel, R. A. A five-year study of 693 psychogeriatric admissions in Queensland. The Geriatrics, 1972, 22, 132-155.

de Beauvoir, S. The coming of age. New York: Putman & Sons, 1972.

DHSS Statistical and Research Report Series No. 10. Censuses of: A. Patients in mental illness hospitals and units in England and Wales at the end of 1971. B. Mental illness day patients in England and Wales at April, 1972. HMSO, 1975.

Dovenmuehale, R. H., Reckless, J. B., & Newman, G. Depressive reactions in the elderly. Normal Aging, Durham, North Carolina: Duke University Press, 1970, 90-97.

Dunham, A. The new community organization. New York: Thomas, Y. Crowell Company, 1970.

Eisdorfer, C. Attitude toward old people: A re-analysis of the item validity of the stereotype scale. Journal of Gerontology, 1966, 21, 455-457.

Eisdorfer, C. Resources for the aged reflected strongly held social myths. The Centre Magazine, March-April, 1975, 12-117.

Eisdorfer, C., & Atrocchi, J. A comparison of attitudes towards old age and mental illness. Journal of Gerontology, 1961, 16, 340-343.

Engelmann, M., & Cornell, C. Older people in Alberta. Quarterly Statistical Review, January-March, 1975, Department of Social Services and Community Health, Government of Alberta, Edmonton.

Epstein, L. J. Depression in the elderly. Journal of Gerontology, 1976, 31, 278-282.

Essen-Moller, E. Individual traits and morbidity in Swedish rural population. Acta Psychiatric Neurologica Scandanavia, 1956, Supplement 100.

Feldman, S. Community mental health centers: A decade later. International Journal of Mental Health, 1974, 3(2-3), 19-34.

Finkel, S. I. Geriatric psychiatric training for the general psychiatric resident. American Journal of Psychiatry, 1978, 135, 101-103.

Fish, F. Senile schizophrenia. Journal of Mental Science, 1960, 106, 938-46.

Flathman, D. P., & Larson, D. E. Evaluation of three geriatric day hospitals in Alberta. Faculty of Medicine, The University of Alberta, Edmonton, Alberta, 1976.

Fletcher, C. R. How not to interview and elderly clinic patient: A case illustration and the interviewer's explanation. The Gerontologist, Winter 1972, 398-402.

Frankfather, D. The aged in the [illegible]munity: Managing senility and deviance. New York: [illegible]ger Publishers, 1977.

Freud, S. On psychotherapy (190[illegible]. In J. Strachey (ed.), The complete psychological works of Sigmund Freud (vol. 3). London: Hagarth Press, 1963.

Futrell, M., & Wyatt, J. Attitudes of physicians, nurses and social workers toward the elderly. Journal of Gerontological Nursing. May-June 1977, 3(3).

Gaitz, C. M., & Baer, D. E. Characteristics of elderly patients with alcoholism. Archives of General Psychiatry, 1971, 24, 372-78.

Gaitz, C. M. Barriers to the delivery of psychiatric services to the aged persons. Gerontologist, 14, 210-214.

Gatz, M., Smyer, M. A., & Lawton, P. The mental health system and the older adult. In L. W. Poon (ed.), Aging in the 1980's: Psychological issues. Washington, D.C.: American Psychological Association, 1980.

Gibson, R. W. Medicare and the psychiatric patient. Psychiatric Opinion. 1970, 7, 17-22.

Goga, J. A., & Hambacher, W. O. Woodville State hospital, Garnegie, PA. Journal of the American Geriatric Society, 1977, 25(7), 328-330.

Glasscote, R., & associates. Old folks at home. A field study of nursing and board and care houses. Washington, D.C.: American Psychiatric Association, 1976.

Goldstein, S., Sevruik, J., Grauer, H. The establishment of a psychogeriatric day hospital. Canadian Medical Association Journal, 1968, 98 (20), 955-959.

Goldstein, S. Community psychiatry and the elderly. Canadian Medical Association Journal, 1973, 108, 579-583.

Grumber, H. W. Geriatrics: Physicians attitudes and medical school training. Journal of the American Geriatrics Society, 1977, 11, 494-496.

Gurland, B. J. The comparative frequency of depression in various adult age groups. Journal of Gerontology, 1976, 31, 283-292.

Haile, T. A survey of analysis on attitudes of national and international college students toward older people. Dissertation Abstracts International, June 1980, 40(12), 6109-A.

Hagnell, O., & Tuvning, K. Prevalence and nature of alcoholism in total population. Social Psychiatry, 1972, 7, 190-201.

Harris, L., & Associates. The myth and reality of aging in America. National Council on Aging, Washington, D.C., 1975.

Harrington, M. The Other America: Poverty in the United States, New York: MacMillan Co., 1962.

Henery, W. E. The confrontation of the elderly and the mental health professional. Psychiatric Research Reports, 1968, 23, 179-186.

Hendricks, I., & Hendricks, C. D. Aging in mass society: Myths and realities. Cambridge, Mass.: Winthrop, 1977.

Hess, B. B. Stereotypes of the aged. Journal of Communication, 1974, 24(4), 76-85.

Hickey, T., & Kalish, R. A. Young people's perceptions of adults. Journal of Gerontology, 1968, 23, 215-219.

Jolley, D. J., & Arie. T. Organization of psychogeriatric services, American Journal of Psychiatry, 1978, 132, 1-11.

Kahana, B., & Kahana, E. Children's views of their grandparents: Influence of the kinship system. The Gerontologist, 1970, Part II, 10(3), 39.

Kahana, B., & Kahana, F. Changes in mental status of the elderly patients in age-integrated and age-segregated hospital milieus. Journal of Abnormal Psychology, 1975, 75, 177-181.

Kahn, R. L. The mental health system and the future aged. The Gerontologist, 1975, 15, 24-31.

Kaplan, O. J. (Ed.). Psychopathology of aging. New York: Academic Press, 1979.

Katzman, R. The prevalence and malignancy of Alzheimer disease. Archives of Neurology, 1976, 33, 217-218.

Kirkpatrick, S. A. Aging effects and generational difference in social welfare attitude constraint in the mass public. Western Political Quarterly, March 1976, 29, 43-58.

Kobrynski, B. Innovations in programs of care for the elderly. The Gerontologist, 1973, 13(1), 50-53.

Kobrynski, B. The mentally impaired elderly. Whose responsibility? The Gerontologist, 1975, 15 (Part I), 407-411.

Kosberg, J. I., & Gorman, J. F. Perceptions toward the rehabilitation potential of the institutionalized aged. The Gerontologist, 1975, 15, 398-403.

Kramer, J. A. Community mental health centers: Response and responsibility to the aged. In M. Gatz (chair), How can old adults be served by community mental health centers? Symposium presented at the meeting of the American Psychological Association, Toronto, August 1978.

Kramer, M., & Jarvik, L. Assessment of intellectual changes in the elderly. In A. Raskin & L. F. Jarvik (Eds.). Psychiatric Symptoms and cognitive loss in the elderly. Washington, D.C.: Hemisphere, 1979.

Kramer, M. Psychiatric services and changing institutional scene. Paper presented to President's Biomedical Research Panel. National Institute of Health, 1975, Bethesda, Maryland.

Kramer, M., Taube, C. A. & Redick, R. W. Patterns of use of psychiatric facilities by the aged: Past, present and future. In C. Eisdorfer & M. P. Lawton (Eds.) The psychology of adult development and aging. Washington, D.C.: American Psychological Association, 1973.

Lawton, M. P., & Gottesman, L. E. Psychological services to the elderly. American Psychologist, 1974, 29, 689-693.

Lenbra . E. Geropsychology in long term care settings. Professional Psychology, 1979, 10, 475-484.

Libow, L. S. Senile dementia and "pseudosenility". Clinical diagnosis In C. Eisdorfer and R. O. Freid (Eds.), Cognitive and emotional disturbances in the elderly. Chicago: Year Book Medical Publisher, 1977.

Lipscomb, C. F. The care of the psychiatric disturbed elderly patient in the community. American Journal of Psychiatry, 1971, 22(8), 1067-1197.

Lindsey, R. Gerontology is still a very young science. New York Times. June 19, 1977, P.C.

Lowenthal, M. F., & Berkman, P. L. Aging and mental disorders in San Francisco. San Francisco: Jessey-Bass, 1967.

Marquis Academic Media. Sourcebook on aging. Chicago, Illinois: Marquis Who's Who, Inc., 1977.

McTarvis, D. C. Perception of old people: A review of research methodologies and findings. The Gerontologist, Winter 1971, Part II, 90-101.

More, M. T. Education and consultation on mental health in long-term care facilities. Problem, pitfalls, and solutions: An administrator's point of view. Journal of Geriatric Psychiatry, 1977, 10(2), 151-162.

Morrant, J. C. A. Medicine and mental illness in old age. Canadian Psychiatric Association Journal, 1975, 20, 309-312.

Mukerji, B. Community development in India. Delhi, India: Orient Longmans, 1967.

Neilsen, J., Hamma, A., & Bior-Hendriksen, R. Follow-up 15 years after a gerontopsychiatric prevalence study in Samso. 1. Geriatric service by the general practitioners, the local hospitals and the community psychiatric clinic, Comprehensive Psychiatry, 1977, 18, 553-544.

Patterson, R. D. Services for the aged in community mental health center. American Journal of Psychiatry, 1976, 133(3), 271-273.

Payne, B., & Whittington, F. Older women: An examination of popular stereotypes and research evidence. Social Relations, 1976, 23, 488-504.

Peever, M.V. Social and psychological factors influencing application for admission to nursing homes in the city of Calgary. M.A. Thesis. Department of Sociology, University of Calgary, 1974.

Peterson, D. A., & Eden, D. Z. Teenagers and aging: Adolescent literature as an attitude source. Educational Gerontology, July-Sept. 1977, 2(3), 311-325.

Peto, J. Edmonton Journal, Nov. 25, 1980.

Pfeiffer, E. Psychopathology and social pathology. In J. E. Birren & K. W. Schaire (Eds.), Handbook of psychology and aging. New York: Van Nustrand Reinhold, 1977.

Rathbone-McCuan, E. Geriatric day care: A family perspective. The Gerontologist, 1976, 16(6), 517-521.

Redick, R. W., Kramer, M., & Taube, C. A. Epidemiology of mental illness and utilization of psychiatric facilities among older persons. In E. W. Busse & E. Pfeiffer (Eds.), Mental illness in later life. Washington, D.C.: American Psychiatric Association, 1973.

Riely, M., & Foner, A. Aging and society (vol. 1): An inventory of research findings. New York: Russell Sage Foundation, 1968.

Riley, M., & Foner, A. Aging and society (vol. 2). New York: Russell Sage Foundation, 1969.

Robin , E. P. Old age in elementary school readers. Educational Gerontology, July - September 1977, 2(3), 257-292.

Roberts, H. Community development: Learning and action. Toronto: University of Toronto Press, 1979.

Romaniuk. M., Hoyer, F. W., & Romaniuk J. E. Helpless self-attitudes of the elderly. The effect of patronizing statements. Paper presented at the 30th Annual Meeting of the Gerontological Society, San Francisco, November 1977.

Rombout, M. K. Hospital and the elderly: Present and future trends. Staff Papers, Long Range Health Planning. Health and Welfare Canada. 1975.

Rosin, A. J., & Glatt, M. M. Alcohol excess in the elderly. Quarterly Journal of Studies on Alcohol, 1971, 32, 53-59.

Roskin, A. Adverse reactions to phenelzine: Results of a nine-hospital depression study. Journal of Clinical Pharmacology, 1972, 12, 22-25.

Roth, M. Studies in the classification of affective disorders: The relationship between anxiety states and depressive illness. British Journal of Psychiatry, 1972, 121, 146-161.

Roth, M. Prophylaxis and early diagnosis and treatment of mental illness in later life. In W. F. Anderson & B. Isaacs (Eds.) Current Achievements in Geriatrics, 1963, 155-170 (London: Cassell).

Roth, M. Psychiatric disorders of later life. Psychiatric Annals, 1976, 6(9), 57-101.

Sainsbury, P. Suicide in later life. Gerontology Clinics, 1962. 4, 181-170.

Salzman, C., & Shader, R. I. Clinical evaluation of depression in the elderly. In A. Raskin & L. F. Jarvik (eds.), Psychiatric symptoms and cognitive loss in the elderly. Washington, D.C.: Hemisphere, 1979.

Schaie, K. W. External validity in the assessment of intellectual development in adulthood. Journal of Gerontology, 1978, 33, 695-701.

Seefeldt, C., Jantz, R. K., Galper, A., & Serock, K. Children's attitudes toward the elderly: Educational implications. Educational Gerontology, 1977, 2(3), 301-310.

Selltiz, C., Jahoda, D. M., & Cook, S. W. (Eds.). Research methods in social relation. New York: Holt, Rinehart and Winston, 1959.

Seltzer, M. M., & Atchley, R. C. The concept of old: Changing attitudes and stereotypes. The Gerontologist, Autumn 1971, 226-230.

Seltzer, M. M. Differential impact of various experiences of breaking down age stereotypes. Educational Gerontology. April-June 1977, 2(2), 183-189.

Simon, A., Epstein, L. J., & Reynolds, L. Alcoholism in the geriatric mentally ill. Geriatrics, 1968, 23, 125-131.

Simon, A. A. Model for comprehensive mental health care for the aged. In A. N. Schwartz & I. N. Mensh (Eds.), Professional obligations and approaches to the aged. Springfield, Ill.: Charles C. Thomas, 1974.

Signorie, E. I., Butt, D. S., & Kozak, J. Attitudes toward the aged. Dept. of Psychology, University of British Columbia, December 1977.

Soloman, K., & Vikers, R. Attitudes of health workers toward old people. Paper presented at the 30th Annual Scientific Meeting of the Gerontological Society, San Francisco, November 22, 1977.

Skelton, D. The future of health care for the elderly. Journal of the American Geriatric Society, 1977, 25(1), 39-46.

Skelton, D. A review of the psychological changes in aging. Modern Medicine of Canada, 1980, 35(4), 523-527.

Specula, R. Gerontological research instructional program: A final report (GRIP). Submitted by Dallas Public Schools, Oregon, to the Office of Education, Department of Health, Education and Welfare. March 1973, ERIC No. ED 083484.

Statistics Canada Population Projection for Canada and Provinces, 1972-2001, Series A., Series C., Series E., Series F., Ottawa: Queen's Printer, 1974.

Stotsky, B. A. Extended care and institutional care: Current trends, methods and experience. In E. W. Busse & E. Pfeiffer (Eds.) Mental illness in later life. Washington, D.C.: American Psychiatric Association, April 1973.

Tesher, E. Nobody loves you when you're old and gray. Homemaker's Magazine, November 1976.

Todd, R. S. Early treatment reverses symptoms of senility. Hospital and Community Psychiatry, 1963, 17, 170-171.

Thomas, E. C., & Yamamoto, K. Attitudes toward age: An exploration in school-age children. International Journal of Aging and Human Development, 1975, 6, 117-129.

United States Bureau of the Census. Demographic aspects of aging and the older population in the United States. Current Population Reports. Series P-23, No. 59. Washington, D.C.: United States Government Printing Office, 1976.

U.S. Department of Health Education, and Welfare. The nation's use of health resources. Public Health service 1976 Edition. DHEW NO. (HRA) 77-1240.

U.S. Federal Bureau of Investigation. Crime in the United States 1975. Uniform Crime Reports. Washington, D.C. Government Printing Office, 1976.

Vital Statistics of the United States 1970 (vol. 2). Mortality. Rockville, Md.: U.S. Public Health Service, 1974.

Williams, J. R., Kriauciunas, R., & Rodriques, A. Physical, mental and social rehabilitation of elderly and infirm patients. Hospitals and Community Psychiatry, 1970, 21(4), 42-44.

Winn, S., & Kessler, S. Community mental health center and the nursing home patient. The Gerontologist, 1974, 14(4), 345-348.

Wood, W. G. The elderly alcoholic. Some diagnostic problems and considerations. In M. Storandt, I. C. Siegler & M. F. Elias (Eds.), The clinical psychology of aging. New York, 1978.

Zarit, S. H. Aging and mental disorders. New York: Free Press, 1980.

Zimberg, S. Two types of problem drinkers: Both can be managed. Geriatrics, 1974, 29, 135-138.

APPENDIX A

A1 - Psychogeriatric Services Scale (PSS)

A2 - 27 Types of Service

A3 - 4 Groups of Services

PSYCHOGERIATRIC SERVICES SCALE

Several statements regarding mental health services for the elderly are given below. Following each statement, there are six boxes labelled as follows:

Strongly Disagree	*Disagree*	*Slightly Disagree*	*Slightly Agree*	*Agree*	*Strongly Agree*
[]	[]	[]	[]	[]	[]

Please indicate the degree to which you agree or disagree with each statement by checking the appropriate box.

There are no "right" or "wrong" answers -- the only correct responses are those that are true *for you.* In some cases, you may feel you do not have enough information to make judgment. In such instances, please make the best judgment possible.

Please do not spend too much time on any one statement, *but do not skip any items.*
THIS QUESTIONNAIRE IS BEING USED FOR RESEARCH PURPOSES ONLY AND IS COMPLETELY ANONYMOUS.

Thank you very much for your cooperation.

	Strongly Disagree	*Disagree*	*Slightly Disagree*	*Slightly Agree*	*Agree*	*Strongly Agree*	*Do not write in this column*
1. Existing mental health facilities for the elderly need considerable improvement and expansion in order to provide adequate service.	[]	[]	[]	[]	[]	[]	_____
2. Mental hospitals are least suitable for treatment of psychological problems among the elderly.	[]	[]	[]	[]	[]	[]	_____
3. A separate psychogeriatric unit in hospitals and nursing homes is not necessary to deal with psychological problems of the elderly, since most hospitals and nursing homes are well-prepared to handle all kinds of patients.	[]	[]	[]	[]	[]	[]	_____
4. Day hospitals for senior citizens should have provision for both short and long-term rehabilitation programmes.	[]	[]	[]	[]	[]	[]	_____
5. The importance and usefullness of "multiple senior citizen centres" have not been demonstrated clearly.	[]	[]	[]	[]	[]	[]	_____
6. Home visiting psychological and psychiatric services will not reduce the number of older persons admitted to various institutions.	[]	[]	[]	[]	[]	[]	_____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Do not write in this column
7. Professional services of mental health consultants (psychologists, psychiatrists, Social workers) should be made available to older persons living in the community to prevent serious psychological problems.	[]	[]	[]	[]	[]	[]	
8. It is wasteful to open sheltered workshops for psychologically ill old persons.	[]	[]	[]	[]	[]	[]	
9. Regular hospitals or provincial mental hospitals have better facilities to deal with alcohol and drug abuse problems of the elderly then community oriented programmes.	[]	[]	[]	[]	[]	[]	
10. Improved and continual educational programmes concerning old age and its problems are needed for the elderly, their families and community members.	[]	[]	[]	[]	[]	[]	
11. Successful treatment of mental illness among older people is possible only in mental hospitals.	[]	[]	[]	[]	[]	[]	
12. Counselling services are of little or no use to the psychologically disturbed elderly.	[]	[]	[]	[]	[]	[]	
13. Since elderly patients do not differ from other age groups, treatment and rehabilitation facilities should be the same as those designed for the population generally.	[]	[]	[]	[]	[]	[]	
14. Home visiting psychological and psychiatric services are more likely to reduce the number of mentally ill old persons entering various institutions.	[]	[]	[]	[]	[]	[]	
15. Every hospital and nursing home should have a psychogeriatric unit--special psychiatric ward for older people.	[]	[]	[]	[]	[]	[]	
16. Even with good referral and information services, the elderly will seldom make use of the benefits available to them.	[]	[]	[]	[]	[]	[]	
17. The nature of the psychological problems of the elderly is such that community mental health centres will not be very effective in their treatment and rehabilitation.	[]	[]	[]	[]	[]	[]	

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Do not write in this column
18. Older people with psychological problems will benefit more from treatment provided in mental hospitals (e.g. Ponoka, Alberta Hospitals) than the treatment received at community mental health centres.	[]	[]	[]	[]	[]	[]	
19. No matter what kind of improvements are made in transportation service, the elderly are seldom going to use mental health services available for them in the community.	[]	[]	[]	[]	[]	[]	
20. There is a great need for the development of specially designed mental health services for the psychologically disturbed elderly.	[]	[]	[]	[]	[]	[]	
21. In general, senior citizens are not interested in recreational and leisure activities.	[]	[]	[]	[]	[]	[]	
22. Sheltered workshops are helpful in keeping the mentally disturbed elderly away from mental hospitals.	[]	[]	[]	[]	[]	[]	
23. It is a waste of money and human resources to develop and expand special mental health services for the elderly.	[]	[]	[]	[]	[]	[]	
24. Preventive mental health services, such as better health care, facilities, good pension plan, adequate provision for recreational, educational and social activities are likely to reduce the incidence of mental disorder among older people.	[]	[]	[]	[]	[]	[]	
25. Psychiatric and psychological consultation services for the elderly should be made available to all nursing homes and auxiliary hospitals.	[]	[]	[]	[]	[]	[]	
26. Older people with psychological problems should receive treatment in conventional mental hospitals.	[]	[]	[]	[]	[]	[]	
27. Elderly people need counselling services in order to cope with stresses and strains of everyday living.	[]	[]	[]	[]	[]	[]	

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Do not write in this column
28. Day Care centres especially designed for senior citizens offering a variety of care services (e.g., physical, social psychological, recreational, etc.) are more effective than the usual institutional care for the elderly suffering from psychological problems.	[]	[]	[]	[]	[]	[]	
29. It is not a good idea to keep the psychologically disturbed elderly in their own homes regardless of provision for home care services in the community.	[]	[]	[]	[]	[]	[]	
30. Prevention of mental illness among old people can be achieved through improvements in their housing, income, education, nutrition and general health.	[]	[]	[]	[]	[]	[]	
31. Half-way houses are important for rehabilitation and prevention of the psychologically disturbed elderly.	[]	[]	[]	[]	[]	[]	
32. Psychologically disturbed elderly are unlikely to benefit from the services provided by Day Care centres.	[]	[]	[]	[]	[]	[]	
33. Improvement in transportation systems for the elderly is needed so that they can benefit from services available for them in the community.	[]	[]	[]	[]	[]	[]	
34. In order to prevent the development of psychological problems among older people, adequate recreational and leisure time activities must be made available in the community.	[]	[]	[]	[]	[]	[]	
35. Treatment and prevention of mental illness among older persons will be greatly facilitated by "multipurpose senior citizen centres" in the community where comprehensive care services (e.g., personal, social, educational, recreational, medical, psychological, etc.) are made available regularly.	[]	[]	[]	[]	[]	[]	
36. The available resources and facilities are adequate for the professional management and treatment of psychological problems of the elderly.	[]	[]	[]	[]	[]	[]	

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Do not write in this column
37. Modifications in institutional settings are needed in order to care for those elderly for whom institutionalization is the only alternative.	[]	[]	[]	[]	[]	[]	
38. The staff of nursing homes and auxiliary hospitals are well-prepared to care for all kinds of elderly patients.	[]	[]	[]	[]	[]	[]	
39. Mobile and emergency medical and psychiatric services should be provided to the elderly over age 60 whenever they are needed to avoid institutionalization.	[]	[]	[]	[]	[]	[]	
40. Information and referral services are extremely important for many older persons because most of them are not aware of the benefits and services available to them in the community.	[]	[]	[]	[]	[]	[]	
41. We should not extend our responsiblity to care for older mental patients beyond mental hospitals such as halfway houses.	[]	[]	[]	[]	[]	[]	
42. Expansion of Home Health Service under the present Medicare Plan will enable more old persons to use this service instead of full-time institutionalization.	[]	[]	[]	[]	[]	[]	
43. Outreach services (e.g., meals-on-wheels, home-visiting medical services, etc.) are necessary not only to locate older persons in need of psychological help, but also to prevent the development of serious mental illness among the elderly.	[]	[]	[]	[]	[]	[]	
44. Community mental health centres which offer comprehensive mental health services, such as diagnosis, treatment, after-care facilities and prevention are better than mental institutions for mentally disturbed old persons.	[]	[]	[]	[]	[]	[]	
45. Considering the high cost of the Home Service programme, it is unwise to expand this service for serving a large percentage of old persons.	[]	[]	[]	[]	[]	[]	

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Do not write in this column
46. Community members are generally aware of the problems of old age, and as such no special programme is required to educate the public.	[]	[]	[]	[]	[]	[]	
47. It is a luxury to provide mental health consultation services utilizing psychiatrists, psychologists, and social workers to senior citizens since these services are needed more by other age groups.	[]	[]	[]	[]	[]	[]	
48. Mental health services should only be provided to those elderly patients who seek help themselves.	[]	[]	[]	[]	[]	[]	
49. It is doubtful that preventive programmes, such as improved housing facilities, improved nutrition and health conditions, etc. will reduce the incidence of mental illnes among the elderly.	[]	[]	[]	[]	[]	[]	
50. Preventive mental health services are of little value to older people, because they will not decrease the incidence of mental illness among the elderly.	[]	[]	[]	[]	[]	[]	
51. Home care programmes which provide a variety of health treatment and support services to the elderly in their own homes should be made available to keep them psychologically healthy in their familiar environment.	[]	[]	[]	[]	[]	[]	
52. Treatment and rehabilitation of the elderly suffering from alcoholism and drug addiction should be through community oriented programmes.	[]	[]	[]	[]	[]	[]	
53. Elderly patients with psychological problems are more likely to benefit from community based mental health services, such as day care centers, home care services, etc. than the services provided in traditional mental hospitals.	[]	[]	[]	[]	[]	[]	
54. The elderly are less likely to use mobile and emergency medical and psychiatric services because these services are seldom needed by people over age 60.	[]	[]	[]	[]	[]	[]	

Appendix A2

27 TYPES OF SERVICES IN PSS

	Types of Services	Question Nos.	
		Positive	Negative
1.	Day Care Center	28	32
2.	Day Hospitals	4	26
3.	Special Mental Health Services	20	23
4.	Community Based Mental Health Service	53	18
5.	Home visiting Psychological and Psychiatry Services	14	6
6.	Mental Hospital	2	11
7.	Preventive Mental Health Services	24	50
8.	Counselling Services	27	12
9.	Community Mental Health Center	44	17
10.	Out-Reach Services	43	48
11.	Sheltered Workshops	22	8
12.	Psychogeriatric Unit in Nursing Homes and Hospitals	15	3
13.	Home Care Programme	51	29
14.	Mental Health Consultation Services	7	47
15.	Half-way Houses	31	41
16.	Multipurpose Senior Citizen Centers	35	5
17.	Alcoholism and Drug Abuse Treatment Center	52	9
18.	Educational Programmes for Old Age	10	46
19.	Existing Mental Health Services	1	36

27 TYPES OF SERVICES IN PSS (continued)

		Positive	Negative
20.	Psychiatric and Psychological Services in Nursing Homes and Hospitals	25	38
21.	Improved Living Conditions	30	49
22.	Improved Medicare Plan for Home Services	42	45
23.	Mobile and Emergency Medical and Psychiatric Services	39	54
24.	Recreational and Leisure Activities	34	21
25.	Transportation Services	33	19
26.	Information and Referral Services	40	16
27.	Improvement in Institutional Services	37	13

4 GROUPS OF SERVICES IN PSS

GROUP	QUESTION NO.
1. Preventive Services	24, 50, 43, 48, 29, 51, 7, 47, 5, 35, 10, 46, 30, 49, 42, 45, 21, 34, 19, 33, 16, 40
2. Improved Institutional Services	4, 26, 2, 11, 3, 15, 1, 36, 25, 38, 13, 37
3. Community Care Services	28, 32, 20, 23, 53, 18, 6, 14, 12, 27, 44, 17, 9, 52, 39, 54
4. After Care Services	8, 22, 31, 41

APPENDIX B

Old People Scale (OPS)

OLD PEOPLE SCALE

You will find a number of statements below expressing opinions with which you may or may not agree. Following each statement are six boxes labelled as follows:

Strongly Disagree	*Disagree*	*Slightly Disagree*	*Slightly Agree*	*Agree*	*Strongly Agree*
[]	[]	[]	[]	[]	[]

You are to indicate the degree to which you agree or disagree with each statement by checking the appropriate box.

Please consider each statement carefully, but do not spend too much time on any one statement. *Do not skip any items.*

There are no "right" or "wrong" answers - the only correct responses are those that are true *for you.* THIS INVENTORY IS BEING USED FOR RESEARCH PURPOSES ONLY AND IS COMPLETELY ANONYMOUS.

	Strongly Disagree	*Disagree*	*Slightly Disagree*	*Slightly Agree*	*Agree*	*Strongly Agree*	Do not write in this column
1. Old people have too little power in business and politics.	[]	[]	[]	[]	[]	[]	_____
2. In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.	[]	[]	[]	[]	[]	[]	_____
3. There is something different about most old people: it's hard to figure out what makes them tick.	[]	[]	[]	[]	[]	[]	_____
4. Most old people make excessive demands for love and reassurance.	[]	[]	[]	[]	[]	[]	_____
5. Most old people are very relaxing to be with.	[]	[]	[]	[]	[]	[]	_____
6. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.	[]	[]	[]	[]	[]	[]	_____
7. Most old people can generally be counted on to maintain a clean, attractive home.	[]	[]	[]	[]	[]	[]	_____
8. Most old people make one feel ill at ease.	[]	[]	[]	[]	[]	[]	_____
9. Most old people should be more concerned with their personal appearance; they're too untidy.	[]	[]	[]	[]	[]	[]	_____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Do not write in this column
10. Most old people are cheerful, agreeable, and good humored.	[]	[]	[]	[]	[]	[]	
11. Most old people get set in their ways and are unable to change.	[]	[]	[]	[]	[]	[]	
12. It would probably be better if most old lived in residential units with people their own age.	[]	[]	[]	[]	[]	[]	
13. One seldom hears old people complaining about the behavior of the younger generation.	[]	[]	[]	[]	[]	[]	
14. If old people expect to be liked, their first step is to try to get rid of their irritating faults.	[]	[]	[]	[]	[]	[]	
15. It would probably be better if most old people lived in residential units that also housed younger people.	[]	[]	[]	[]	[]	[]	
16. You can count on finding a nice residential neighborhood when there is a sizeable number of old people living in it.	[]	[]	[]	[]	[]	[]	
17. Most old people are capable of new adjustments when the situation demands it.	[]	[]	[]	[]	[]	[]	
18. Most old people bore others by their insistence on talking about the "good old days".	[]	[]	[]	[]	[]	[]	
19. People grow wiser with the coming of old age.	[]	[]	[]	[]	[]	[]	
20. Most old people seem to be quite clean and neat in their personal appearance.	[]	[]	[]	[]	[]	[]	
21. There are few exceptions, but in general most old people are pretty much alike.	[]	[]	[]	[]	[]	[]	
22. Most old people are irritable, grouchy, and unpleasant.	[]	[]	[]	[]	[]	[]	
23. Most old people are really not different from anybody else; they're as easy to understand as younger people.	[]	[]	[]	[]	[]	[]	
24. One of the most interesting qualities of old people is their accounts of their past experiences.	[]	[]	[]	[]	[]	[]	

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Do not write in this column
25. Most old people need no more love and reassurance than anyone else.	[]	[]	[]	[]	[]	[]	
26. Most old people respect others' privacy and give advice only when asked.	[]	[]	[]	[]	[]	[]	
27. It is foolish to claim that wisdom comes with old age.	[]	[]	[]	[]	[]	[]	
28. It is evident that most old people are very different from one another.	[]	[]	[]	[]	[]	[]	
29. Most old people are constantly complaining about the behavior of the younger generation.	[]	[]	[]	[]	[]	[]	
30. Most old people spend too much time prying into the affairs of others and in giving unsought advice.	[]	[]	[]	[]	[]	[]	
31. Old people have too much power in business and politics.	[]	[]	[]	[]	[]	[]	
32. When you think about it, old people have the same faults as anybody else.	[]	[]	[]	[]	[]	[]	
33. Most old people would prefer to quit work as soon as pensions or their children can support them.	[]	[]	[]	[]	[]	[]	
34. Most old people tend to let their homes become shabby and unattractive.	[]	[]	[]	[]	[]	[]	

Thank you very much for your cooperation.

APPENDIX C

Demographic Information Questionnaires (DIQ)

DEMOGRAPHIC INFORMATION QUESTIONNAIRE

Please complete the following questions. *This information will be used for research purposes only and is completely anonymous.*

Do not write in this column

1. Age: _____

2. Sex: Male ____ Female ____

3. Marital Status: Single ____ Widowed ____ Separated ____
   Married ____ Divorced ____ Common-law _____

4. Number of Children: ____ Ages: 0-4 ____ 5-9 ____ 10-14 ____
   15-19 ____ 20+ ____

5. Birthplace: _____ (City/Town) _____ (Country)

6. Ethnic Background: European ____ African ____ Asian ____
   West Indian ____ Middle Eastern ____
   Native Canadian ____ Others _____ (specify)

7. Residence Status: Citizen ____ Permanent Resident ____

8. Immigration Year: _____ (if applicable)

9. Religion: _____

10. Education Completed:

Elementary	Jr. & High School	College/University	Vocational/ Technical
1 2 3 4 5 6	7 8 9 10 11 12	1 2 3 4 5 6 7 8	1 2 3 4

11. Employment Status: Employed ____ Unemployed ____ Retired ____ Student ____

12. Occupation/Profession: _____

13. Occupation/Profession of Spouse _____ (if applicable)

14. Gross Annual Household Income of 1980:

... under $ 5,000 ____	$25,001 - $30,000 ____
$ 5,001 - $10,000 ____	$30,001 - $35,000 ____
$10,001 - $15,000 ____	$35,001 - $40,000 ____
$15,001 - $20,000 ____	$40,001 - $45,000 ____
$20,001 - $25,000 ____	$45,001 & over .. ____

Do not write in this column

15. Is your father living? Yes ____ No ____

16. Is your mother living? Yes ____ No ____

17. Living arragement of your parents(s).

    Own home ____ with you ____ Institution _____ (specify)

18. If your parents live separately, how often do you see them?

    Daily ____ Weekly ____ Monthly ____

    Annually ____ Less often ____ Never ____

19. Are your grandparents living?

    Paternal Grandfather Yes ____ No ____
    Paternal Grandmother Yes ____ No ____
    Maternal Grandfather Yes ____ No ____
    Maternal Grandmother Yes ____ No ____

20. Living arrangement of your grandparents:

    Own home ____ with you ____ Institution _____ (specify)

21. If your grandparents live separately, how often do you see them?

    Daily ____ Weekly ____ Monthly ____

    Annually ____ Less often ____ Never ____

Thank you very much for your cooperation

APPENDIX D

Covering Letter Sent with the Questionnaires

INTERDISCIPLINARY M.A. PROGRAM
IN COMMUNITY DEVELOPMENT

THE UNIVERSITY OF ALBERTA
EDMONTON, ALBERTA, CANADA
T6G 2G5

To: Head of the Household

Dear Sir/Madam:

The Division of Community Development at the University of Alberta is supervising a research study by a graduate student (Mrs. Asha Sinha) concerning the problems of senior citizens.

The main purpose of the research is to find out what kind of mental health services for senior citizens are preferred by community members. This information will be useful to the government, social service agencies and community workers in designing suitable mental health services for the elderly.

We would very much appreciate it if you would kindly take some time to answer the enclosed questionnaire. Since you are not required to write your name on the questionnaire, your answers will remain completely confidential.

A brief summary of the results will be prepared at the completion of this study. If you wish to receive the summary, please send me your name and address in a separate letter so that your answers cannot be identified.

Please send the completed questionnaire in the enclosed stamped and self addressed envelop at your earliest convenience. If you have any questions please call Mrs. Sinha at 435-5160.

Thank you very much for your time and interest in this project.

Sincerely,

Dr. A.S.A. Mohsen,
Acting Director
Division of Community Development